PUBLIC HEALTH

LONDON: THE SOCIETY OF MEDICAL OFFICERS OF HEALTH
Tavistock House South, Tavistock Square, W.C.1

No. 2.-Vol. LXVII. MONTHLY PRICE 2s. 6d. ANNUAL SUBSCRIPTION 31s. 6d. NOVEMBER -1953

PUBLIC HEALTH

OFFICIAL JOURNAL OF THE

SOCIETY OF MEDICAL OFFICERS OF HEALTH

Telephone: EUSton 3923 TAVISTOCK HOUSE, TAVISTOCK SQUARE, LONDON, W.C.1 Telegrams: Epidauros, Westcent

No. 2. Vol. LXVII NOVEMBER, 1953

CONTENTS

EDITORIAL

The Minister on Cooperation

The Minister of Health has again taken the opportunity of his address to the annual meeting of the Executive Councils' Association to express his thoughts on developments in the National Health Service. In last year's address* he outlined the ways in which cooperation between general practitioners and the local health department team might be encouraged and, at the 1953 meeting† he has presented a "situation report" on the same topic with some further suggestions which will no doubt be considered most carefully by both Executive Councils and Local Health Authorities. His references to the inquiry into health visiting under Sir Wilson Jameson are of particular interest, for he clearly wishes to be given some definite advice about the future relationship of the health visitor to the many other types of social worker now engaged in the local domiciliary field.

Our own impression is that cooperation with the general practitioners is going ahead much more rapidly than it is with the hospital service, with some notable exceptions. Too often do we still read in annual reports and elsewhere the plaints of medical officers of health at the lack of information from hospitals about patients who are due to be discharged and likely to be in need of after-care and about morbidity in general. No one can blame the Ministry for the failure of hospital boards and management committees to take notice of the circulars from the central department which have urged the transmission of information to M.O.H.s in order to enable them to cooperate more effectively in restoration of health or the prevention of controllable ill health. The vast hospital service has, alas, no representative body comparable with the Executive Councils' Association. If it had, we should dearly like to hear the Minister speak out to its annual meeting in the same way as he talks to the representatives of the Executive Councils.

To revert to the Minister's recent speech, the part of it which he devoted to the dental service concerns public health dentistry as well as general practice, for he discussed with admirable logic the true facts of the situation. It is abundantly clear that there is no prospect of meeting the Teviot Report standards of dental manpower and we fail to see how the dental profession can continue to resist the introduction of dental ancillaries on the New Zealand model. On another measure, the prevention of caries by fluoridation, the Minister is clearly aware of the force of the United Kingdom Mission's report, though unable to commit himself wholeheartedly because of the Mission's inexplicable cautiousness about the immediate introduction of this urgently needed measure wherever it is needed in this country, that is, wherever natural fluorine is absent or deficient.

* PUBLIC HEALTH (November, 1952), **66**, 27.

† *Med. Offr.* (October 24th, 1953), **90**, 203.

Private Legislation

At the September Meeting of the Society's Council (see report p. 25, minute 178) mention was made of the local powers obtained in Private Bills promoted by individual authorities and of the useful pioneer experience thus acquired. It is felt that many of these local enactments are "born to blush unseen" by others who might profit by them. Members whose authorities have obtained powers with a bearing on public health are asked therefore to inform the Administrative Officer so that enquiries from other members on recent developments can be answered. These items will also be reported in the journal for the information of all who may be interested.

The Working Party on Health Visiting

The Ministers of Health and Education and the Secretary of State for Scotland have appointed a Working Party to advise on the proper field of work and the recruitment and training of health visitors in the National Health Service and School Health Service. The chairman will be Sir Wilson Jameson, G.B.E., K.C.B., M.D., F.R.C.P., formerly Chief Medical Officer, Ministries of Health and of Education, and its members Dr. A. Beauchamp (City of Birmingham Executive Council); Alderman Mrs. K. Chambers, C.B.E., LL.D., J.P. (Bradford City Council and Executive Council); Miss E. G. Himsworth (Nursing Supervisor, Midlothian and Peebles); Miss E. Stephenson (Chief Nursing Officer, Newcastle upon Type), and Dr. J. F. Warin (M.O.H. and S.M.O., City of Oxford).

The Working Party will be advised by a Steering Committee, also under the chairmanship of Sir Wilson Jameson, on which the Government Departments concerned will be represented. It will also represent the English and Scottish Associations of Local Authorities concerned and the London County Council; the Welsh Joint Education Committee and the Association of Education Committees; the Royal Sanitary Institute, and the Standing Conference of Health Visitor Training Centres approved by the Minister of Health. It will also have the expert advice on social workers and their training of Miss Eileen Younghusband, M.B.E., J.P., and Prof. R. M. Titmuss.

The inquiry is expected to deal with the general position of the health visitor in the National Health and School Health Services in the light of experience now gained (including, for example, ways in which she might co-operate with the family doctor and the hospitals) but not with services with which the appointing Ministers are not directly concerned.

The joint secretaries are Mr. R. Pronger and Miss M. H. Cook, S.R.N. (Ministry of Health, Chesham House).

THE ORGANISATION OF PREVENTION*

By VICTOR FREEMAN, M.R.C.S., L.R.C.P., D.P.H.,
Medical Officer of Health, Metropolitan Borough of Islington

The costs of the nationalised health services—or sickness services, as some prefer to call them—have been the subject of almost continual discussion in political and medical circles since 1948. No party, however, seems prepared to take the responsibility of cutting or altering the Service to ensure a major cut in expenditure. The increasing complexity of medical technique and the inheritance of old and out-of-date hospital buildings, apart from many other reasons, preclude the present possibility of any worthwhile reductions, which can only be sensibly effected by diminishing the demand and necessity for hospitalisation and treatment. It is unlikely that short cuts will soon be found to this desirable end, but medical officers of health have a natural interest in prevention, even if its application and effects can only be long term.

Before going on to consider the possibilities of the preventive method, I hope I may be allowed a few minutes to summarise and place in perspective the current costs of the health and sickness services.

Health Service Finances

The Civil Estimates for 1953-54 provided approximately £433,000,000 for England and Wales in respect of the Hospital Services, grants to Local Health Authorities, the General Medical, Dental, Pharmaceutical and Supplementary Ophthalmic services, and other items.

The ceiling figure for Health Service expenditure from taxation was fixed at £400,000,000 in 1950 and this figure has been retained by Chancellors of the Exchequer for each succeeding year. The value of services obtainable with this sum must, of course, be diminished by increased costs, including salaries, which have taken place since 1950.

Local Health Authority services are paid for partly by central Government grants and partly from the local rates, and the total Local Health Authority estimates for 1952-53 were approximately £43,000,000. The cost of health services not under the control of the Local Health Authorities, although not easily separable, cannot be a major item of expenditure. Winslow gives the figure of £67,500,000 as the cost of preventive services in England, Wales and Scotland for the year 1949-50, against an all-inclusive National Health Service cost for the same period of £425,000,000—more than six times as much.

The public itself also contributes an increasing amount through payments for specific services which may amount to some £30,000,000 per annum.

The view has been expressed by some that expenditure of this order on sickness and health services may have a major detrimental effect on the national economy, but *The Times*, and also a recent P.E.P. Report, have pointed out that the Health Service is not having so large a share of the national income as is commonly supposed. If related to the gross national income, the Health Service accounts for about 3½% of the nation's current spending, private and public, on goods and services. This is not, of course, to say that £400,000,000 or so is not a major item, and there is certainly no excuse for unnecessary or wasteful expenditure at any point in the health services.

Of the total of public spending on the health services, it has been estimated that £300,000,000, or 63%, is now taken by the hospital and specialist services. This disproportionate expenditure between the curative and preventive services appears to be fairly general. Winslow, in "The Cost of Sickness and the Price of Health," mentions that in Denmark the State spends nearly three times as much on hospitals as on basic public health work. The same applies in Sweden, but in Great Britain the proportion is approximately six to one.

* Paper read to the Metropolitan Branch, Society of M.O.H., September, 1953.

Value for Money ?

In a recent *Times* survey the question was asked, "What return does the community get for the £300,000,000 or so poured into the hospital and specialist service ?"

"Something under a fifth goes on the care of mental patients and mental defectives, a branch of the service which is getting into a parlous state for want of funds. What happens to the rest is only vaguely known, except in particular places. What is the cost of caring for the tuberculous, of provision for maternity, children, or the chronic sick, of the increasing demands on out-patient facilities made by general practitioners ? How much of what the hospitals ask for each year is really essential for their efficiency as medical institutions ? To these and many more questions it is very difficult to give coherent answers relating to the country as a whole.

"It is known that the efficiency, both medical and economic, of hospitals varies widely and haphazardly. Restriction of budgets has stimulated the cutting down, without detriment to patients, of a good deal of expenditure on food, fuel, and other resources, which should never have been tolerated."

The Times correspondent might have gone on further to point out that, on the other hand, the Local Health Authority Services, with a much smaller total expenditure, were carefully scrutinised, and it was possible without any difficulty to give separate headings of expenditure for such services as maternal and child health, midwifery, home care, vaccination and immunisation, etc. Perhaps the most striking contrast, however, is that whilst Hospital Management Committee and Regional Hospital Board financial estimates and statements are regularly published, there is no corresponding information on the work which is the purpose of this expenditure. So little systematic information, in fact, is available that a special survey has had to be undertaken to collect morbidity statistics relating to hospital in-patients. A preliminary survey has now been published under the title of "Hospital Morbidity Statistics," but while some valuable information has become available, the balance sheets of work for patients cannot be related to the financial balance sheets.

The Hospitals and Prevention

Some consultants themselves are not altogether satisfied that the hospital services are operating in the most advantageous way, or are doing anything very effective towards reducing the burden of hospital demands. Professor Vines, in an address to the Institute of Hospital Administrators, confessed himself tired of these massive hospital accounts and statistics which, however excellent they might be in demonstrating saving to the Exchequer, were quite uninformative about the real work of the hospital, which was the care of the patient and the control and prevention of sickness. He went on to say that a hospital was also a place for investigation into the causes of disease and the methods of treatment. The nationalised hospital, he said, must become the statistical and functional embodiment of the national policy for the management of the sick, but at present it was not very obvious that there was any particular policy of medical care. The long-term policy should be to empty the hospitals rather than fill them. Medicine to-day was concerned primarily with the cure of disease, or the patching-up of tissues, but it should become increasingly preventive in its aim.

Dr. Bomford, in his Bradshaw Lecture at the Royal College of Physicians in 1952, said, "It seems inescapable that sooner or later we shall come, or indeed we shall be driven by the economic pressure of the cost of sickness, to regard the prevention of disease and promotion of health as more important than the curative or more often palliative medicine to which at present we devote so much more attention." He then went on to discuss in abstract the concept of Health, and concluded by saying, "It is no accident that academic medicine has no concept of health; for the mechanistic idea of disease leaves no room for one, other than in terms of no disease, which is clearly inadequate."

Whatever the theoretical inadequacies might be, I should have supposed that a condition of no disease would be an advance in the right direction over disease being present, but in any case Dr. Bomford made no practical suggestions on the introduction of the preventive principle into hospital practice.

Sir Heneage Ogilvie, in the Annual Oration to the Medical Society of London in 1952, said, "Were we to ask modern students 'What is the purpose of medicine?' none would answer, 'To heal the sick.' They would say, 'To prevent illness' or 'To discover the cause of disease.' A scientific rather than a humanitarian ideal." I find it difficult to see why the prevention of illness is not just as humanitarian an objective as the immediate treatment of a sick patient.

From the representative samples of consultants' views on prevention just quoted, there would seem to be some awareness of the preventive problem, but little attempt to deal with it. This is natural, since those who have spent their lives in curative medicine can hardly be expected to think readily along other lines, and the technique of preventive medicine is not, in general, attractive to clinicians.

There is also the human factor of the vested interests of particular groups. Dr. Topping, in his Presidential Address to the conference of medical officers of health at the last Health Congress of the Royal Sanitary Institute, referred to the sudden enthusiasm amongst general practitioners for ante-natal and maternity work, so markedly at variance with the attitude of 90% of doctors between the wars; and also to the number of consultants who were transferring from full-time to part-time hospital work. Dr. Dixon, of Leeds University, has also referred to the hospital boards' inherent reluctance to be interested in prevention, which can only result in the reduction of professional and administrative empires.

However, before we throw stones, we must recognise that the preventive services necessarily and unavoidably also have their own vested interests. I think the difference is that the vested interests of the preventive service are much more in accord with the general public interests as compared with the curative service. It should therefore be regarded as the duty of the service that practical proposals for the introduction of preventive medicine into the curative sphere shall be made by the preventive service itself. All of us pay lip-service to prevention, which cannot become a practical proposition until machinery is devised which will permit application of preventive principles to curative medicine. Further, it is only the practitioners of preventive medicine who have been specifically trained for preventive work, and surely it is in the public interest that full use should be made of this training.

I am proposing to make certain suggestions, and the principle underlying these suggestions is that certain groups of sickness, widespread in the community, and making large demands upon the hospitals in particular, are influenced to some extent by social and environmental factors. If this is so, then systematic recording of these factors may provide information which will eventually be helpful towards the diminution of these particular major causes of sickness, so reducing the burden of expensive portions of the medical services. Following this, I shall consider how the preventive service might be allowed to play a proper part while closely linked to clinical work.

Before considering non-infectious sickness treated at general hospitals, I should like, as an aside to the principal subject matter of this talk, to mention one infection which might be considered for inclusion in the list of notifiable diseases by the customary procedure.

Infective Hepatitis

Infective hepatitis belongs to that small but important group of infectious diseases which from time to time bursts with almost explosive violence into epidemics of pandemic proportions. Normally it has a low mortality, about 0·2% of cases, but it usually incapacitates patients for weeks or months, and it reached fairly widespread proportions during the second world war.

Infective hepatitis appears to be at present a more serious disease than diphtheria or scarlet fever, and I frequently receive information of sporadic cases reported to me by some general practitioners. It is notifiable only in the counties of Bedfordshire, Essex, Hertfordshire, East and West Suffolk, Cambridgeshire, Huntingdonshire, Isle of Ely and Norfolk. From 1944 to 1950 the notifications varied from a maximum of 3,500 to a minimum of 1,000 approximately. In 1950 they numbered 1,823, and the number increased gradually in the three years prior to this. The highest incidence of notifications is in the five to nine age group. All these counties are mainly rural and have no very large centres of population, therefore notification does not necessarily give any indication of what the incidence of infective hepatitis might be in large urban areas.

When it is realised that in 1951 notifications over the whole country of diphtheria were approximately 2,000, those of acute poliomyelitis 3,100, and those of meningococcal infections approximately 2,000, it is obvious that infective hepatitis must be a fairly widespread disease. It is also not medically negligible, and the Registrar General records the following deaths from infective hepatitis in the three years given :—

1949	1950	1951
230	284	255

These deaths are exceeded for deaths due to infectious disease only by measles, poliomyelitis (some years), meningococcal infections and whooping cough.

Information for the country as a whole, local variations, local seasonal incidence, if any, etc., are unknown factors, and there would seem to be a case for adding infective hepatitis to the list of notifiable infectious diseases, all the more so since we know so much less about virus infections than bacterial infections.

Cancer of the Lung

Passing now to consideration of the epidemiology of non-infectious disease, there appears to be general agreement that there has been a genuine basic increase in cancer of the lung in recent years, and that the increase cannot be wholly ascribed to greater medical awareness and improved diagnosis.

In 1951 there were 11,166 male deaths from cancer of the lung, and the crude death rate per milliom was 530, against corresponding figures in 1931 of 1,635 and 85 respectively. In 1951 there were 7,903 male deaths from respiratory tuberculosis with a crude death rate per million of 375. Female deaths from cancer of the lung were 2,081 in 1951 against 651 in 1931.

When deaths from cancer of the lung are sub-divided into separate sites, deaths from cancer specified as actual cancer of the lung increased among males by 66% between the ages 40 to 49, but cancer specified as of the bronchus increased by 283%.

As a cause of hospitalisation, cancer of the lung was third in the number of discharges for males aged 45 to 64 years, and constituted the highest single group for malignant neoplasms in males. Cancer of the lung and stomach together represented 37·9% of malignant growths among men in the Hospital Morbidity Survey. Prior to 1948 the stomach was the most frequent site for male cancers at all ages, but in that year cancer of the lung, which had been reported with rapidly increasing frequency in previous years, supplanted cancer of the stomach as a single leading cause of male cancer mortality.

Apart from the considerable sex differentiation in cancers of the lung, there are also considerable geographical variations. The death rates for males and females are given in Table I.

TABLE I: LUNG CANCER MORTALITY

	Greater London	County Boroughs outside Greater London	Urban Districts outside Greater London	Rural Districts outside Greater London
		Males		
Death rate per million	594	517	396	296
Cancer of respiratory system as percentage of cancer of all sites	29	25	20	16
		Females		
Death rate per million	113	95	82	79
Cancer of respiratory system as percentage of cancer of all sites	6	5	5	5

The principal factors which have been blamed for the increase in lung cancer are :—

(1) The increase in tobacco smoking.

(2) The smokiness of the atmosphere, either by itself producing or stimulating lung cancer, or reducing sunshine, which may be an important factor in preventing its incidence.

Road dust and petrol engine exhaust gases have also been mentioned as possible contributory causes.

Whatever the final verdicts in regard to causation may be, it would seem to be obvious that social and environmental factors have played a major part in lung cancer increase, and if these factors can be defined, they may point the way to steps which can be taken for reduction of lung cancer, if not to its elimination.

Lung cancer would therefore seem to be an eminently suitable subject for enquiry along epidemiological lines.

Peptic Ulcer

Peptic ulcer is a disease of great social and economic importance. The sex incidence has changed during the last 50 years, and from being high in young females and low in young males, it is now high in young males and low in females. It has been estimated that there are 1,000,000 peptic ulcer patients in this country to-day and that 10% of men in the late forties have an active duodenal ulcer.

There is also a geographical variation of incidence. The mortality rates for peptic ulcer for men over 45 are approximately 75% higher in the County of London than in the rural areas. Again, there is a considerable sex differentiation. In the Hospital Morbidity Enquiry there were 1,066 discharges of males with stomach ulcer as against 425 females (nearly two and a half times greater) and 2,200 males with duodenal ulcer as against 415 females (five times).

Peptic ulcer is also a major cause for hospitalisation. It was responsible for the highest number of hospital discharges of any single condition in the male age-group 15 to 44, and accounted for 8% of all male admissions. The proportionate age distribution for the duodenal type of ulcer reached its peak at an earlier age than that for gastric ulcer. For men in the age-group 45 to 64 it accounted for about 1 in every 10 admissions.

In view, therefore, of the social as well as personal factors involved, peptic ulcer should yield profitable dividends to systematic epidemiologic enquiry.

Domestic Accidents

Domestic accidents, to which are ascribed 5,000 to 6,000 deaths annually, and where the tendency is for an increase to take place each year, constitute a major group of fatalities. About 20% of the fatalities occurred in children under five years of age, and about 60% in those over 65 years ; but more children under 15 die from accidental causes in the home than are killed on the roads.

Non-fatal domestic accidents which require minor treatment must constitute a considerable burden of work to practitioners and hospitals, but there are no statistics available which will give a comprehensive picture of the volume of medical treatment done for non-fatal accidents.

The reasons for accidents are partly personal and partly social and environmental, and must therefore be regarded as preventable to some extent. There must be local variations in incidence as well as causes, and these can only be ascertained, with the appropriate advice to be given, and propaganda to be undertaken or other measures to be adopted on information gathered locally. The Medical Officer of Health should have such information systematically from practitioners and hospitals.

Hospitalised Morbidity Among Women

Among women aged 15 to 44, obstetrical conditions and diseases of the congenital tract predominate. The discharges relating to pregnancy and childbirth amounted to 25·7% of the total, and at least one in every two admissions at aged 15 to 34 related to obstetrical conditions, among which over half were admissions at term for normal or other deliveries.

Apart from hospitalisation in connection with childbirth and pregnancy, the principal causes for hospital admission in women age-group 15 to 44 were appendicitis, menstrual disorders, tuberculosis, fibro-myomata of the uterus and utero-vaginal prolapse, in that order. For women aged 45 to 64 by far the highest number of admissions were due to utero-vaginal prolapse and fibro-myomata and other benign uterine neoplasms, again in this order. Utero-vaginal prolapse is, therefore, a very common and important cause of female invalidism, frequently over a very prolonged period. It is mainly associated with child bearing, but not invariably so, and social and environmental factors may well play a part in the exacerbation, if not causation, of this condition. There is little precise information as to the extent of invalidism and semi-invalidism caused by this condition, especially in middle-aged women, and epidemiological enquiries should yield useful information.

Tonsillectomies

It has recently been estimated that of the total on the national hospital waiting list of 500,000 or so, some 150,000 are awaiting admission for tonsillectomy.* According to the Hospital Morbidity Statistics, 31% of all admissions for children of school age were attributed to tonsils and adenoids. It was also mentioned that the burden on hospital resources, though heavy, was not quite so heavy as the figure of 31 in every 100 discharges might suggest, for while tonsils and adenoids accounted for about 5% of discharges at all ages, the corresponding proportion of bed-days was just under 1%, owing to the short average stay. However, although the turnover of cases of "Ts and As" is rapid, a very great total of time for operative work must be involved and a good deal of nursing attention must be given during the short stay in hospital.

Apart from the amount of hospital work done in connection with tonsillectomies, there is another aspect which should also be considered. Tonsillectomy is not in itself without risk. Apart from the associated risks such as poliomyelitis and cross-infection in hospital wards, the Registrar General has given the following figures for deaths associated with tonsillectomies :—

	1939	1942	1945	1948
0 to 5 years ...	21	24	15	15
5 to 15 years ...	37	39	26	32
	58	63	41	47

*The Ministry of Health Report for 1952 (Part 1) gives in page 133 an E.N.T. waiting list of 171,455 cases at 31st December, 1952. It is assumed that the great majority of these were for tonsillectomy.

It is unfortunate that after 1948 the International Classification of Deaths no longer gives information of conditions associated with tonsillectomy, but deaths are ascribed to hypertrophy of tonsils and adenoids. It would be reasonable to assume that by far the greater part of these deaths are due not to hypertrophy but to associated tonsillectomies. The total deaths due to hypertrophy of tonsils and adenoids were :—

1949	1950	1951
40	49	43

The operative risk with possible fatal consequences is not, therefore, altogether negligible.

It has been pointed out that tonsillectomy is hardly ever performed as an urgent operation in children, and even if not performed, the sequelae of the conditions for which tonsillectomy is recommended are very rarely fatal in themselves. Tonsillectomy deaths are all the more tragic since approximately two-thirds of all tonsillectomy deaths occur in those under the age of 15 years.

Tonsillectomy is the most frequent surgical procedure necessitating a general anaesthetic but there are tremendous variations in local tonsillectomy rates, *e.g.*, in 1948 a Birmingham child was four times more likely to be tonsillectomised than one living in Manchester. Bristol trebled the pre-war rate, but the Leeds rate was reduced to one-fifth. The Herefordshire rate was six times the Gloucestershire, and Buckinghamshire had a rate five times greater than its neighbour, Bedfordshire.

Glover said, "The eccentricities of this incidence distinguish it from any other surgical procedure," and T. B. Leyton in 1948 expressed the view that the profession as a whole should reconsider its approach to tonsillectomy. The Ministry of Education had, short of dictation, done all it could to limit the number arising from school inspections, and still it went on to such an extent that it could only be explained as being due to disharmony of the human mind. He believed that future generations would wonder at it just as we do at the bleeding and purging at the end of the 18th century.

The *British Medical Journal* was exceptionally categorical on this matter in 1948. It said that there are certain aspects of tonsillectomy which justify definite statements. It is a major operation, never urgent, and it should be preceded by a period of observation of six months after the completion of any necessary treatment of teeth and sinuses ; it should not be performed in winter or early spring, nor when infectious diseases are prevalent ; and it seldom improves the condition of patients with established systemic diseases such as nephritis or rheumatism. There must be extreme doubt as to whether all the 300,000 waiting tonsillectomies are likely to have these criteria satisfied.

Have areas with high tonsillectomy rates better child health than areas with low tonsillectomy rates ? It would seem extraordinary that after all the tonsillectomies that have been done no definite answer can yet be given. It would seem to be very timely, therefore, that there should be systematic advance information, recording, and follow-up in regard to every tonsillectomy done and that this should be done in conjunction with, but also independently of, the surgical specialty.

Incidentally, if the average stay in hospital is five days, and the average cost per child bed is taken as £3 10s. 0d. per day, there would be a saving of £1,750,000 in hospital costs for every 100,000 tonsillectomies not performed.

Rheumatism

Rheumatism, being somewhat of a diagnostic rag-bag, is not so simple of approach from the epidemiological angle. It is only 14th in the Causes of Death, but it is responsible for a vast amount of invalidism. It has been estimated that it was responsible in one year for the loss of 3,000,000 working weeks, an expenditure of £2,000,000 on sickness benefit, and caused one-sixth of the total industrial invalidism.

The epidemiological aspect should certainly be included in any review of the rheumatic problem.

Preventive Work in the Hospitals

So much for an outline of some of the problems to be tackled or considered for action. Now what existing machinery in any of the medical services can be extended or adapted so that the practice of prevention is as much taken for granted by the hospital service, even if only in a small way initially, as is the necessity for any form of curative treatment required for any sick patient ?

An extension of notification to include the non-infectious diseases is one step which has been proposed by some. Dr. Dixon has said that " if the Medical Officer of Health of the future is to be continuously aware of the state of the public health, he must be able to evaluate the medical, social and economic problems of many diseases. He cannot do this without figures. In the case of cancer of the lung we are obviously in the early stages of an epidemic process of unknown duration ; and as with other diseases, the most suitable time to study cause is during an epidemic phase. As history shows, the causative factors can be postulated with some accuracy by epidemiological study, and some degree of control achieved without knowing the specific cause. If it were tackled in this way we should have the greatest chance of achieving some control. "

At first sight, notification may appear an attractive, obvious, and relatively simple method of obtaining the information required, but would it really suffice ? To begin with, all that need be included in the present notification form is the name, address, age, sex, date of onset and disease from which the patient is suffering. These particulars would obviously be insufficient even as a basis for the epidemiological recording and evaluation of lung cancer, peptic ulcer, etc.

Secondly, we are all aware of the difficulties we encounter from the hospitals, even with the simple Infectious Disease Notification statutorily required, and which should be traditional by now. Is it not likely that the difficulties and delays would be considerably greater with notification of the non-infectious diseases, especially if more information were required than for infections ?

For many reasons, a domiciliary visit by the Medical Officer of Health's staff to fill the lacunae might be unprofitable, undesirable or unnecessary, especially as much, if not all, of the data required is already available in the patient's case-history and hospital records. What would be required for this purpose is, therefore, an extract from the patient's routine history sheets, supplemented by such further enquiries as experience showed to be desirable, and which could be obtained at the patient's hospital attendance. Domiciliary visiting would be done to amplify socio-medical data, but not necessarily as a routine.

If this line of approach is correct, then it follows that that part of the patient's history which has epidemiological significance should be separately drawn up and be available or extractable for use and retention by the Medical Officer of Health. He will have to work in close co-operation with the hospital consulting and senior medical staff, and his status is therefore important. It might also be better for the records to be kept at the hospital instead of in the public health department, and to be associated with the general hospital records.

An alternative to notification is therefore that medical records in an approved and agreed form be transmitted to or extracted by the Medical Officer of Health, who will be made formally responsible for this part of the work in respect of such non-infectious diseases as may be statutorily specified. To carry out this function effectively will probably necessitate the appointment of the Medical Officer of Health to the hospital staff as a consultant epidemiologist in its widest sense (or perhaps consultant aetiologist). He would not, of course, have any hospital beds, but the important nature of his responsibility should be recognised by consultant status, not only for equality in dealing with

his most senior colleagues, but also as a public indication of the importance of this function by the State.

The appointment should not, of course, be whole-time and the principal appointing authority should remain the local authority. The present functions of the M.O.H. have still to be carried out, but apart from this, if the hospital became the principal employer, it might well tend to submerge, in the course of time, the importance of the preventive objective.

My suggestion that the Medical Officer of Health might be appointed on the hospital staff has some points of similarity with the recommendation made by Prof. Leslie Banks in his address on "The Future of Local Authority Health Services" in 1952. Prof. Banks believes that the prevention and cure of diseases are no longer to be regarded as distinct entities to be retained in separate administrative and technical compartments, but that prevention, diagnosis, treatment and after-care now form one continuous process, and that we should revise our undergraduate and postgraduate teaching accordingly. He also stated that the first step which would allow the Medical Officer of Health to co-ordinate the local medical services, if he had the full and active support of his colleagues, would be to give him an honorary contract on the staff of the local group of hospitals as Home-care Physician. It would then be his duty to ensure that all existing resources were used to prevent disease arising in the individual, as well as to encourage the medical care of patients in their own homes, etc.

Since the Medical Officer of Health will have no beds, he will not require, as do other consultants, a registrar, senior and junior housemen, almoner, etc. He will, however, in all probability, require the services of a statistical assistant, who may or may not be already available on the hospital staff. It might well be a logical development that eventually the whole of the hospital morbidity recording, when developed, should pass under the aegis of the M.O.H. as consultant epidemiologist. Initially, however, only a very limited number of selected conditions, such as lung cancer and peptic ulcer, need be singled out for epidemiological treatment.

With regard to the possible number of such appointments, there are 378 Hospital Management Committees in England and Wales, and 36 Board of Governors, making a total of 414 hospital groups. However, the special hospital groups, *e.g.*, mental, need not be considered for this purpose, and this would therefore leave something under 400 hospital groups available for the making of preventive appointments.

There are obviously many aspects which would have to be considered before arriving at a decision on general hospital epidemiologists. Hospital epidemiology should be linked with neighbourhood epidemiology, but hospital group areas may cover more than one local authority area, each with an M.O.H. In such cases should each M.O.H. be appointed to the same group to link respectively with his own area, or should only one appointment be made, the person appointed referring domiciliary investigations to his colleagues for the area? Consideration of this factor leads to the possible suggestion that each local health area shall be based upon the local hospital group, but important implications such as this must remain part of long-term policy. The introduction of preventive practice into the hospitals should not be delayed for such settlements, since hospital economy calls for more immediate steps. In any case, the appointment of medical officers of health to the hospitals from existing local authority areas will provide valuable information and experience for some time to come, before further developments are likely to take place in health authority areas in the years to come.

The setting up of a small, but distinct, general epidemiological-statistical department in the hospital would have a further very important advantage, especially in the teaching hospitals. The medical student, in the course of his training, is so taken up with pathology and the diagnosis and treatment of disease that he can hardly be made aware of prevention. And yet if the practitioner of the future is ever to have a different outlook and play a larger part in the health services and the promotion of health than he does at present, it is absolutely essential that he be taught prevention in his student days. Can prevention of disease and its practice be emphasised in any better way within the hospital than by making each student serve for a short period in the preventive department under the consultant epidemiologist, just as he does his medical clerking and surgical dressing. Incidentally, the teaching of students should also serve as a moral and intellectual stimulus to the epidemiologist himself.

Additional appointments of epidemiologists and statistical staff may add a little in the first place to the hospital salaries bill. It would, however, be a relatively minor item, but unless the standard of hospital care and attention is substantially lowered, there is no present hope of worthwhile reductions in the cost of the hospital service. On the contrary, with the continued complexity of medicine on the one hand, and the necessity sooner or later for major capital expenditure on old hospital buildings—and this cannot be postponed indefinitely—there is every likelihood that hospital costs will go up and not down. Since no one really desires that sick persons shall be treated on the cheap, long-term reduction in curative service costs can only be brought about sensibly by reducing the necessity for medical and especially hospital treatment. From the economic point of view, therefore, a small premium paid now on insurance by the preventive service may be returned manyfold in the future, as has already occurred with diphtheria and the primitive hygiene diseases with which we are no longer afflicted in this country.

I am well aware of many difficulties and snags which may be encountered in trying to implement the suggestions I have put forward. But the problems to be dealt with which I have mentioned are generally accepted as requiring to be tackled urgently.

Prevention is frequently mentioned, but on how to begin to make it work there has been singularly little discussion, and I have therefore felt somewhat impelled to step in where others, probably wiser, have not trodden.

Finally, may I say that perhaps the preventive service has been too modest about itself in the past—and also the present. We have made insufficient impact on the public and the politicians. "Prevention is better than cure" has become too familiar a saying, being so generally accepted that it is automatically ignored. I think if I were going to put an alternative title to this talk it would be "Prevention is *cheaper* than cure!" If this became publicised it might perhaps make a little more impression on the politicians, with benefit both to the public and the preventive service.

BIBLIOGRAPHY

BANKS, A. LESLIE. (1952.) *Brit. Med. J.*, **2**, 1007.
BOMFORD, R. R. (1953.) *Ibid.*, **1**, 633.
Children in Road Accidents. (1953.) *Lancet*, **1**, 1032.
Civil Estimates, 1952–53, Class V.
Civil Estimates, 1953–54, Class V.
COHEN, SIR HENRY. (1951.) *Proc. Roy. Soc. Med.*, **40**, 443.
DALEY, SIR ALLEN. (1953.) Croonian Lectures. *Brit. Med. J.*, **2**, 163 and 243.
DIXON, C. W. (1952.) *Lancet*, **2**, 1131.
DOLL, RICHARD, & AVERY JONES, F. (1951.) Occupational factors in the aetiology of gastric and duodenal ulcers. Spec. Rep. Ser. Medical Research Council, No. 276. H.M.S.O.
DOLL, RICHARD, & BRADFORD HILL. (1952.) *Brit. Med. J.*, **2**, 1271.
———. (1953.) *Ibid.*, **1**, 505.
Epidemiology of accidents. (1953.) *Lancet*, **1**, 730.
Epidemiology of virus hepatitis. (1952.) *Brit. Med. J.*, **1**, 1399.
GEARY. (1952.) *Ibid.*, **2**, 625.
Health Service Costs. (1953.) *Ibid.*, **1**, 723.
LAYTON, T. B. (1948.) *Ibid.*, **2**, 310.
MACKAY, DONALD. Hospital Morbidity Statistics, General Register Office.
MCNEE, SIR JOHN. (1952.) *Brit. Med. J.*, **1**, 1367.
MINISTRY OF HEALTH. (1950.) National Health Service, Development of Consultant Services. H.M.S.O.
———. (1953.) National Health Service, Hospital Costing Returns for March 31st, 1952. H.M.S.O.
———. Report for year ended March 31st, 1949.
———. Report for year ended March 31st, 1950, Part II.

Ministry of Health. Report of, Part I, March 31st, 1950.
———. Report of, Part I, 1950.
———. Report of, Part III, 1951.
———. Report of, Part II, April to December, 1951.
———. Report of, Part I, 1952.
Notification of Disease. (1952.) *Brit. Med. J.*, **1**, 474.
Nuffield Provincial Hospitals Trust, Report, 1948–51.
OGILVIE, SIR HENEAGE. (1952.) *Lancet*, **2**, 820.
PEMBERTON, JOHN. (1953.) *Lancet*, **2**, 469.
Political and Economic Planning, Cost of Social Services, 1932-52.
Registrar-General's Statistical Review, England and Wales, Part I, 1948.
Ibid., Part I, 1951.
Removal of children's tonsils. (1948.) *Brit. Med. J.*, **2**, 564.
Smoking and lung cancer. (1952.) *Ibid.*, **2**, 1299.
STOCKS, PERCY. (1952.) *Munic. Eng.*, **130**, 168.
Tasks for the M.O.H. (1952.) *Lancet*, **1**, 87.
The Times, March 27th, 1952.
———, February 25th, 1953.
———, February 26th, 1953.
TOPPING, A. (1953.) *Roy. San. Inst. J.*, **73**, 520.
VINES. (1953.) *Brit. Med. J.*, **1**, 1104.
WINSLOW, C. E. A. (1951.) W.H.O. Monograph Series. The Cost of Sickness and the Price of Health. Geneva.

RECENT ADVANCES IN THE TREATMENT OF THE RHEUMATIC DISEASES*

By G. D. KERSLEY, T.D., M.D., F.R.C.P.

During the last few years there have been several recent advances in the treatment of the rheumatic disease, but no "cures." The new treatments will only be advances, however, if used in conjunction with the already established principles of treatment.

Rheumatoid Disease

In rheumatoid arthritis—or better rheumatoid disease, as the joints are only one small part of the tissues affected—relief from stress, care of the general health, mental and physical rest, treatment of anaemia, removal of obvious sepsis, care of affected joints and possibly aurotherapy, are the first considerations. In addition A.C.T.H., cortisone, hydrocortisone and butazolidine may be valuable adjuvants to treatment in selected cases.

First it would be in order to consider cortisone and A.C.T.H. and their practical value. They are antiphlogistic or anti-inflammatory rather than anti-rheumatic and they may be used as an "asbestos suit" to protect the patient temporarily from the fire of the disease, but they will neither put out the fire nor deal with the ashes. The dosage needed varies very greatly from patient to patient and this factor, and the length of time for which "cover" is required, largely define their value.

In rheumatoid arthritis they may be used with advantage (1) to cover a sudden emergency or acute exacerbation of the disease; (2) to assist in reductions of deformity by splintage and manipulation; (3) for those cases that flare up after surgery; (4) to rehabilitate borderline cases who are almost but not quite fit for light work or almost ambulant; and (5) for long-term treatment where a very small dosage of cortisone, 25 to 50 mg. per day, makes a very great clinical improvement.

In choice of hormone to be used, cortisone is best for long-term treatment, hydrocortisone used locally for reduction of deformity, especially of knees, and when the condition affects few joints or there is a contra-indication to general use. A.C.T.H., especially as the long acting gel, is of great service given by injection once a day, or even on alternate days, as a stimulus for short-period treatment.

The contra-indications and dangers can be grouped as (1) the inherent result of the antiphlogistic effect—masking of symptoms, reduction of reaction against infection and lengthening of time of healing; (2) production temporarily, while a large dose is being taken, of a Cushing syndrome with mooning of the face, hirsutes, amenorrhoea, etc.; and (3) upset of salt and water metabolism, with oedema usually controlled by restriction of salt. Occasionally, potassium deficiency may result. The general use of these hormones is as a rule inadvisable in diabetes—they cause a temporary diabetogenic tendency as well as lowering the renal threshold to sugar—in active tuberculosis unless used with streptomycin and carefully controlled, in cardiac failure because of salt and water retention and in psychoneurosis and psychosis because of their euphoric effect, which is often followed by irritability or depression.

Phenyl butazone (butazolidine) rivals the pituitary adrenal hormones in the controversy it has raised. In some rheumatoid cases, the effect on pain and hence spasm, mobility and indirectly on the general health is so dramatic that some almost bedridden patients can be got back to light work. The effect on the sedimentation rate is, however, slower and less constant than with cortisone. The use of butazolidine carries dangers, the most serious of which, but least common, is agranulocytosis. Gastric irritation and sometimes haemorrhage are not unusual, rashes are common but not severe, and oedema, due to salt retention but not to damage to the kidneys, is, as a rule, of little importance. Agranulocytosis, however, occasionally arises even on small dosage and with no warning—routine white counts are valueless. Butazolidine should be used only when rheumatoid disability is severe and where there is a response to small dosage—200 to 600 mg. (one to three tablets) per day. Intermittent administration should be avoided as it may increase the risk of sensitisation and *the patient* should be told to report at once if he or she feels ill, runs a temperature for no obvious cause, or gets a sore throat or mouth. Daily white counts should then be carried out and a screen of antibiotics commenced. Transfusion and A.C.T.H. may be indicated. Sternal marrow examination will show evidence of change before the peripheral blood.

Osteoarthritis

In osteoarthritis treatment has altered little the principles of rest, exercises and heat, but radiotherapy has proved of benefit in some 50% of cases and surgery has advanced a great deal. The Judet acrylic head is competing with the vitellium cup in the treatment of the osteoarthritic hip. Their results in relief of pain and usually improvement in mobility are good, provided the degree of disability and the patient's age justify these major operations. The Judet operation entails a little less trauma and is indicated for the aged, but it is certainly less durable than the cup.

Ankylosing Spondylitis

In ankylosing spondylitis the preservation of posture is the key to treatment—postural and breathing exercises, bed boards or plaster bed, a light brace and especially radiotherapy are of proven value. Cortisone and A.C.T.H. produce temporarily dramatic results, as in many cases of rheumatoid arthritis, but the effect of radiotherapy is longer lasting. Hormone therapy should be used for correction of posture in women of the child-bearing age when radiotherapy is contra-indicated and when the patient has already received the maximal safe dosage of radiation.

Gout

Gout is a partially hereditary and gonad controlled dyscrasia of uric acid metabolism, fired off by stress or allergy. Basic treatment is still the same, but A.C.T.H. may be used for rapid control of symptoms to be followed immediately by colchicine to prevent a "rebound" attack. Cortisone may sometimes be of value in severe tophaceous gout on a longer term basis. Butazolidine may also have a very powerful therapeutic effect.

Benamid in a dose of 0·5 to 2 gm. per day has been used in gout. It causes a very marked increase in the uric acid excretion and fall in plasma uric acid, but it may actually provoke an attack of gout. Its place in treatment is not really yet established. It seems however that it may be of value if continued for long periods, a year or more. Colchicine is still the main-stay of drug treatment in this disease, though it affects neither the blood level nor ex-

* A paper read to the West of England Branch, Society of M.O.H., May, 1953.

cretion of uric acid. It can now be used intravenously (3 mg. in 3 c.c. N. Saline) in case of urgency and where gastric irritation precludes its use by the mouth.

Brevity may not always be the soul of wit, but it is certainly the father of dogmatism. It is hoped that the latter will be excused in view of the merit of the former.

SOCIETY OF MEDICAL OFFICERS OF HEALTH

NOTICES

Annual General Meeting

Notice is hereby given that the Annual General Meeting of the Society will be held at Tavistock House, Tavistock Square, London, W.C.1, on Thursday, December 10th, 1953, at 5.30 p.m.

AGENDA

1. Minutes.
2. Correspondence.
3. To receive the Annual Reports of the Council, the Honorary Treasurer and the Editor of PUBLIC HEALTH for the session 1952–53; and to adopt the Balance Sheet and Income and Expenditure Accounts for the year ended September, 1953 (to be published in the December issue of PUBLIC HEALTH.
4. To authorise the Council to appoint the Auditors for the session 1953–54.
5. Election of Fellows (list of candidates to be published in December PUBLIC HEALTH).
6. Nominations for the next election.

By Order,
S. R. BRAGG,
Administrative Officer.

November 1st, 1953.

METROPOLITAN BRANCH

President: Brig. A. E. Richmond.

A meeting will be held in the Conference Hall, Ministry of Health, Savile Row, W.1, on Friday, November 13th, 1953, at 5 p.m. There will be a discussion on "Poliomyelitis—development, epidemiology, virology and preventive aspects," opened by Dr. W. H. Bradley.

F. M. DAY,
Hon. Secretary.

Town Hall,
Hammersmith, W.6.

MATERNITY AND CHILD WELFARE GROUP

A General Meeting of the Group will be held on Saturday, November 7th, 1953, at 2.15 p.m., in the Old Library, B.M.A. House, Tavistock Square, W.C.1, when Dr. Hilda Davis (Senior M.O., Bucks C.C.) will speak on "Samples of the Child Health Services in U.S.A." Members are invited to attend the meeting of the Metropolitan Branch on November 13th (see notice above).

Please note the following dates when other Group General Meetings will be held:—

Friday, December 4th.
Saturday, February 6th.
Friday, March 5th.
Saturday, April 3rd.

Dr. D. A. CRAIGMILE,
Hon. Secretary.
Dr. M. T. PATERSON,
Hon. Asst. Secretary.

SERVICES GROUP

President: Dr. G. M. Frizelle, T.D.

The first meeting of the Group in the 1953–54 session will be held on Friday, November 13th, 1953, at 5.30 p.m., in Room 310, London School of Hygiene and Tropical Medicine.

Speaker—Andrew Topping, Esq., T.D., M.A., M.D., F.R.C.P., D.P.H.

Subject—"The Lighter Side of International Health."

The address will be followed by a Group Council Meeting.

Group Annual Dinner

By kind permission of the Commandant (Major-General F. C. Hilton-Sergeant, Q.H.P.) the Annual Dinner of the Group will be held in the R.A.M.C. Headquarter Mess, Millbank, on Friday, December 4th, 1953, at 7 for 7.30 p.m. The R.A.M.C. Band will be in attendance. The cost per head will be £1 exclusive of wines. Members may bring guests, but the total number must not exceed 70. If applications exceed this number, places will be dealt with according to priority of application. Dress: Mess dress, evening dress with decorations or dinner jackets with miniatures. Members are requested to send application with remittance to the Hon. Secretary as soon as possible and not later than November 20th. Names should be written in *block* letters.

Please note also the following dates:—

January 22nd, 1954—Annual General Meeting and Presidential Address.

February 19th, 1954—Meeting at the Royal Army Medical College, Millbank.

R. F. GUYMER,
Hon. Secretary.

L.S.H. & T.M.,
Keppel Street,
(Gower Street),
W.C.1.

REPORTS

EXTRAORDINARY MEETING

An Extraordinary Meeting of the Society was held in the Lecture Theatre of the London School of Hygiene and Tropical Medicine, London, W.C.1, on Thursday, September 17th, 1953, at 5 p.m., the President for 1952–53, Dr. Andrew Topping, in the chair, to consider a Special Resolution as follows:—

> "That the name of the Association be changed from 'The Society of Medical Officers of Health' to 'The Society of Preventive Medicine,' and that the Articles of Association of the Company be amended accordingly."

The President, opening the meeting, expressed his pleasure and that of the Council at the large attendance of members. The matter before the meeting was serious and important. He wished to say that there was no possible suggestion of anyone being persuaded against his will to vote for the proposed change, nor was there any need for impassioned oratory on one side or the other.

The question of a change of name had been before the Society for many years, the reason for the suggestion was that the whole composition of the Society had changed in the last 20 years; there was not now a preponderance of medical officers of health in the membership but a minority. Out of 2,125 there were 529 medical officers of health, with 849 deputy or assistant medical officers of health. Previously no satisfactory alternative name had presented itself, but in July, 1952, the Council received a recommendation from a joint meeting of the County and County Borough Groups that the name of the Society should be changed to "The Society of Preventive Medicine" and it was decided to take the preliminary steps to see if the change would be accepted by the Board of Trade. In February, 1953, it was reported that the Board of Trade would be willing to accept the name. In accordance with the Companies Act a change of name could only be decided upon at an extraordinary general meeting of the Society concerned by a two-thirds majority of those present and voting by a show of hands.

In view of the difficulty of getting members to a meeting a complete postal vote was taken with the result that there were 937 votes for the change and 160 against it. That did not alter the fact that a meeting must be held and that there must be a two-thirds majority in favour before a change could be made.

There had been criticism that the matter should have been referred to Branches and Groups. However, the attendance at Branch and Group meetings was not fully representative and a vote at such meetings would not give such a good indication as would be obtained from a postal vote. It was always open for an individual member of the Society to bring the matter before his Branch or Group if he wished.

He thought that the Council had acted in a very democratic way to try to get the feeling of the Society on this matter and the Council felt that a decision must be come to one way or the other. He would like to have the feelings of members and therefore invited short comments before the vote was taken.

A Member asked if he could move an amendment, but the **President** said that the resolution as drawn in the notice of the meeting must be adhered to.

Dr. Fleming (Gosport) said that he would suggest that the Society should be "The Society of Medical Officers of Health and Preventive Medicine." It was misleading to say that the medical officers of health were in a minority, that was true if one spoke of statutory medical officers of health, but he maintained that deputies and assistant medical officers of health were as much medical officers of health as the statutory ones. Their interests were bound up together and that was why he put forward an amendment.

The President replied that the meeting was called for the specific purpose of deciding whether to agree to the change of name as stated in the resolution.

Dr. T. Ruddock-West (Norfolk) protested against the change of name. In the postal ballot many members did not realise what the change meant, it was only in thinking it over that members, particularly in his remote and backward part of the country, objected to it very strongly.

Dr. J. Tudor Lewis (Wandsworth) said that anything which reacted in any way on the status or dignity of the office of medical officer of health must react on the whole of the service and on

every single member. There was in this suggestion the possibility of disunity, and dissension in the public health service would be fatal at the present time. He hoped everybody would vote against the resolution.

Prof. Leslie Banks (Cambridge) said that on administrative grounds it seemed to him that to invite Fellows of the Society to agree to the change of name without giving them the opportunity of discussing it in the Branches or otherwise indicated inefficiency or autocracy. Secondly, he had been a Fellow of the Society for 18 years and he had had great pleasure in it, but he would not retain that affection for a Society of Preventive Medicine which would not give him any advantages which he could not get elsewhere. He would not remain a Fellow merely to get the journal. If this went through—this was not a threat but a statement—it was in his mind to explore the possibility of forming an Association of Teachers of Public Health. The abandonment of the present title was tantamount to abandoning faith in the medical officer of health himself with all that implied both for the present and future. It was creating a dangerous precedent for countries overseas which required a preventive service rather than a curative service. It would be most unfortunate if it was advertised that the Fellows of the Society of Medical Officers of Health had lost faith in their title. For these reasons he proposed to vote against the proposal.

Dr. John Yule (Stockport) said that as one of the 937 who voted for a change of name his recollection was that there was a unanimous vote for a change of name at the Branch meeting which he attended. He also attended a meeting of the Fever Group—it would be enlightening to some members to attend a meeting of that Group which had no benefits at all and who would like to suggest that there was no place for it within the Society. He thought the chest physicians were feeling aggrieved and the changed position required a review of the name. He was strongly in favour of the new name.

Another member said that as one of the 160 who voted against he regarded the change as retrograde from the point of view of public health and health in general. The general trend nowadays was to stress health as opposed to disease and it would be disastrous to cut out the word "health" altogether from the title of the association and substitute it for the negative and relatively retrograde conception embodied in the phrase "preventive medicine."

Dr. N. Parfit (Abingdon) spoke as one of those who voted for but now proposed to vote against. He agreed very much with the first speaker that the average deputy medical officer of health or assistant medical officer of health had no objection to being mistaken for a medical officer of health. He was a medical officer of health of a particular variety and had no objection to belonging to a Society which had the name "The Society of Medical Officers of Health." Adding the two groups together gave a total of 1,400, which out of 2,100 was about 70% of the membership and the present name should be continued.

The President said that there was a tremendous amount of cogency in what had been said about the proportion of people who were deputy or assistant medical officers of health, but there were other groups in the public health services, the armed services, the laboratory services, the fever hospital people, the tuberculosis people—there were still a few who were interested in the prevention of tuberculosis—and quite a big group of others, including a proportion of general practitioners. It must be remembered that a large number of medical officers of health or their deputies or assistants did vote for a change of name and for this title, and he would remind the meeting again, without trying to force the issue or his own point of view, that in 1952 the County and County Borough Groups actually suggested this name to the Council, so that the Council was not suggesting something which had not been suggested by one of the most important bodies of the Society.

Dr. H. K. Cowan (Essex) said that when this matter was considered by the County and County Borough Groups one of the points put forward most forcibly was that the name was a purely functional name, that it gave the impression that the Society was a Society of Medical Officers who were medical officers of health only. Whether an assistant medical officer or a deputy medical officer or a maternity officer liked to be taken for a medical officer of health was beside the point. The suggestion was that it might be possible to attract people who were on the fringe of the public health service by having a broader name which would induce those in the ancillary services to join the Society. This would not only be of financial benefit to the Society but of great benefit as bringing other aspects of work and practice into the Society, something which was not within the narrow field of the medical officer of health. He could not see that this change of name would make any difference to the people already in the Society. Whether an assistant medical officer wanted or liked to be thought of as a medical officer of health would not affect the actual working of the Society, there would be no alteration in the people eligible for membership, all that it was hoped to do was to broaden the basis of the Society from a functional title to people who were in the ancillary services. There were always people opposed to change but one had to forget prejudice in this matter.

Dr. C. F. White (City of London) said that he was not satisfied with the name "The Society of Medical Officers of Health" but he definitely did not like the name "The Society of Preventive Medicine." He thought they were to be apostles of positive health, which was something more than preventive medicine.

The resolution was then put to the vote with the following result:—

Against	...	78
For	...	31

and it was declared lost.

The President assured the meeting that the Council would not have any hard feelings, and expressed his gratification at the good humour with which the matter had been debated.

The meeting then terminated.

ORDINARY MEETING

An Ordinary Meeting of the Society was held in the Lecture Theatre, London School of Hygiene and Tropical Medicine, on Thursday, September 17th, 1953, at 5.30 p.m.

The chair was taken by the retiring President, Dr. Andrew Topping, and there were also present approximately 160 members.

Minutes. The minutes of the meeting held on May 22nd were confirmed and signed.

Installation of the President. Dr. Andrew Topping said that it gave him great pleasure to install as his successor Dr. C. Metcalfe Brown, M.O.H. of the City of Manchester. He then invested Dr. Metcalfe Brown with the Badge of Office, and the latter briefly thanked the Society for the honour which had been bestowed upon him. A hearty vote of thanks to the retiring President was proposed and carried with acclamation. Dr. Topping thanked the Officers and Staff of the Society for the support which had been given to him during his year of office.

Candidates for election. The following candidates having been proposed and seconded were elected to membership:—

As Fellows:—Arratoon, Lily, L.R.C.P. (LOND.), M.R.C.S., M.R.C.O.; Archer, Thomas Chamney Russel, M.B., B.S., L.R.C.P. (LOND.), M.R.C.S., D.P.H.; Broomhead, Cawthorne Lishman, M.D., B.CH., D.P.H.; Collins, Michael Joseph, M.B., B.CH. (N.U.IREL.), D.P.H; Fielding, Arthur, L.D.S., R.C.S. (EDIN.); Fleming, Mary I., M.B., B.CH., D.C.H.; Hargreaves, Irene, M.B., CH.B. (LEEDS); *Hiscock*, Winifred Margaret, L.R.C.P.&S. (EDIN.) L.R.F.P.&S. (GLASG.), D.P.H. (LOND.); Kolibabka, G. A., M.A., M.B., CH.B.; Milne, John Coutts, M.B., CH.B., D.P.H. (ABERD.), D.T.M.&H.; Reynolds, George Morton, M.B., B.CH.; Rowles, Amelia, B.SC., M.B., B.CH., D.P.H.; Sked, Andrew Gardner, M.B., CH.B., D.P.H. (GLASG.); Steane, Margaret, M.B., CH.B. (BIRM.); Steele, Ronald, L.D.S.; Symonds, Hedwig, M.R.C.S., L.R.C.P. (LOND.).

Associates:—Crawford, Richard, L.D.S., R.C.S.I.; O'Connor, Maurice Claude, M.B., B.S., M.R.C.S., L.R.C.P. (LOND.).

Presidential Address. Dr. C. Metcalfe Brown then delivered his Presidential Address on "The National Public Health Service" (published in the October issue of PUBLIC HEALTH, page 2). The meeting then terminated.

COUNCIL MEETING

A meeting of the Council of the Society was held in the Council Room of the B.M.A. on Friday, September 18th, 1953, at 10 a.m.

Present.—Dr. J. M. Gibson (in the Chair), Dr. C. Metcalfe Brown (President), Drs. F. A. Belam, R. T. Bevan, W. H. Bradley, F. G. Brown, George Buchan, J. S. G. Burnett, H. D. Chalke, T. M. Clayton, H. M. Cohen, H. K. Cowan, C. K. Cullen, Sir Allen Daley, Drs. James Fenton, Miriam Florentin, F. Gray, Kathleen M. Hart, A. S. Hebblethwaite, C. E. Herington, J. H. Hudson, J. Maddison, J. B. S. Morgan, A. A. E. Newth, A. G. Reekie, T. Ruddock-West, H. L. Settle, J. F. A. Smyth, Esq., L.D.S., Drs. J. A. Stirling, Andrew Topping, F. R. Waldron, W. S. Walton, Nora I. Wattie, Ann Mower-White, H. C. Maurice Williams, Prof. G. S. Wilson, Dr. W. Woolley, Maj.-Gen. T. Young and Dr. J. Yule. Dr. A. V. Kelynack, Assistant Secretary, B.M.A., was also present.

Apologies for Absence were received from Prof. Fraser Brockington, Sir John Charles, Drs. F. M. Day, R. H. G. H. Denham, J. D. Kershaw, W. R. Martine, Maurice Mitman, R. H. Parry, G. H. Pringle and E. J. Gordon Wallace.

Before the commencement of the meeting Dr. C. Metcalfe Brown referred to the cocktail party held on the evening preceding the meeting, at which members of the Society had been

guests of the London School of Hygiene and Tropical Medicine, and expressed the Society's grateful thanks to the Governors of the School. Dr. Topping responded suitably.

161. **Minutes of the Last Meeting.**—The minutes of the meeting of the Council, held on Friday, May 22nd, 1953 (PUBLIC HEALTH, July, pages 161–164) were confirmed and signed by the Chairman.

162. **Co-option of Members to Serve on the Council** (*Min.* 108).—Ballot papers having been collected and counted the Chairman declared the following elected under the Articles of Association, as members of the Council for the Session 1953–54 :—

Under Article 19 (*d*).—Prof. C. Fraser Brockington, Drs. James Fenton and Hugh Paul.

Under Article 19 (*f*).—Dr. George Buchan, Sir John Charles, Sir Allen Daley and Prof. G. S. Wilson.

163. **Distribution of Transferable Deaths** (*Min.* 110).—The Chairman welcomed Mr. R. M. Blaikley, of the General Register Office, who was present at the meeting during the consideration of this matter. After hearing Mr. Blaikley the members present felt that they could not express approval of the new arrangements proposed by the General Register Office for the transfer of registerable deaths without considerable further discussion, and it was resolved to refer the matter for consideration at the next meeting of the General Purposes Committee. Mr. Blaikley kindly undertook to be present at the meeting.

164. **Infant Mortality Statistics.**—It was agreed that the Society offer no objection to the temporary suspension of the classification of infant mortality in social classes.

165. **Accommodation for Medical Inspections in Schools** (*Min.* 114).—It was reported that this matter was still under consideration by the School Health Service Group.

166. **Ministry of Education Circulars** (*Min.* 115).—This matter also was still under consideration by the School Health Service Group.

167. **British Post-Graduate Medical Federation** (*Min.* 116).—Sir Allen Daley reported briefly on the discussions which he had had with the Director of the Federation, regarding this matter.

168. **Report of General Purposes Committee.**—Dr. H. K. Cowan presented the report of the meeting of the General Purposes Committee held on Friday, July 10th, 1953 (Appendix "A").

Min. 128. *Whitley Medical Functional Council*

(*a*) Dr. Kelynack reported verbally on various matters which were receiving the attention of Committee "C."

(*b*) A letter dated August 4th, from Dr. C. W. Shearer, was received. The letter requested the Society to press for some action to be taken to remove the anomalies existing as a result of the recent award to Assistant Medical Officers. It was agreed that Dr. Shearer be informed that this question was being considered by Committee "C".

Min. 129. *Review of the Society's Finances.*—It was reported that the Sub-committee appointed by the General Purposes Committee had held its first meeting, and that further meetings were to be held.

Min. 131. *Training of Health Visitors.*—It was reported that it was hoped that the draft evidence prepared by the Sub-committee would be before the Council at its next meeting.

Min. 132. *D.P.H. Committee.*—It was reported that Prof. R. H. Parry had had to withdraw from membership of the D.P.H. Committee, owing to ill health, and that Prof. C. Fraser Brockington had been appointed Chairman of the Committee in his stead. The document setting out the Committee's findings would be submitted as soon as possible.

Min. 137. *Children with Defective Hearing.*—It was reported that a letter dated August 1st from the Ministry of Education had forwarded a revised draft of the circular which it was intended should be sent to local education authorities. The amended circular had been submitted to the School Health Service Group, who asked for further time to consider the matter in view of the fact that some entirely new proposals had been inserted into the final draft. It was agreed that a letter be addressed to the Ministry of Education asking for the issue of the circular to be postponed until the Society's recommendations had been formulated and considered.

Min. 139. *Notification of Infectious Diseases.*—A letter dated August 26th from the Chief Medical Officer, Ministry of Health, asked the Society whether Medical Officers of Health would welcome, at weekly intervals, information obtained by the laboratory services on the occurrence of non-notifiable infectious or communicable diseases. It was understood that at present the information from the laboratory services was not yet complete and it might be some time before any arrangements could be brought into operation. It was resolved that the Chief Medical Officer be advised that such information would be of great benefit to Medical Officers of Health in their work and that the Society would be grateful if the possibility suggested in Sir John's letter were to be pursued further.

Min. 144. *Cost of the National Health Service.*—The minutes of the two meetings of the Cost of the National Health Service Sub-Committee were received. The procedure to be adopted by the Society for the preparation and presentation of the evidence for submission to the Guillebaud Committee was fully discussed, particularly in the light of the agreement between the Society and the B.M.A. on the question of consultation on medico-political matters. On the suggestion of the representatives of the B.M.A. present at the meeting, it was agreed that arrangements be made for consultations to proceed side by side with the preparation of the evidence of both the Society and the B.M.A.

It was noted that it might be necessary to hold a special meeting of the Council to consider this matter.

Min. 145. *Rehabilitation of Disabled Persons.*—It was reported that a sub-committee had been appointed to consider the preparation of evidence for submission to the Committee of Enquiry on the Rehabilitation of Disabled Persons, with the following membership :—

Drs. C. Metcalfe Brown, J. L. Burn, J. S. G. Burnett, I. G. Davies, J. T. Keddie, Llywelyn Roberts, A. B. Semple, H. L. Settle, James Wood-Wilson and John Yule,

and that evidence was in course of preparation.

Min. 149. *Notification of Outbreaks of Puerperal Infection.*—It was reported that arrangements had been made for Dr. G. E. Godber to attend the next meeting of the General Purposes Committee so that further consideration could be given to this matter.

Min. 153. *Immunisation.*—A letter dated August 10th from the Medical Defence Union was received. The letter set out fully the points which had been borne in mind in stating the opinion that a Medical Officer of Health might be held to have acted wrongfully in allowing nurses in certain circumstances to work on their own initiative, by giving injections without previous medical examination of the children and without medical supervision.

Arising from the consideration of this matter it was agreed that the General Purposes Committee consider the question of the Form of Consent which is signed by parents for immunisation purposes.

Min. 154. *Prevention of Food Poisoning in School Canteens.*—The Council received and endorsed the document containing the comments forwarded to the Ministry of Education on this matter.

Min. 157. *Industrial Disease.*—It was reported that a Sub-committee had been appointed to consider the preparation of evidence to the Departmental Committee which had been set up to Review Certain Provisions of the Industrial Injuries Act. The membership of the Sub-committee was as follows :—

Drs. C. Metcalfe Brown, J. L. Burn, J. S. G. Burnett, I. G. Davies, J. T. Keddie, Llywelyn Roberts, A. B. Semple, H. L. Settle, James Wood-Wilson and John Yule.

Min. 160. *Representation—North Regional Association for the Deaf.*—It was reported that Dr. W. S. Walton was unable to accept the invitation to represent the Society on this Association. It was agreed that Dr. J. L. Burn (Salford C.B.) be asked to represent the Society.

Subject to the above amendments and additions, the minutes of the General Purposes Committee were received and the recommendations contained therein adopted.

169. **Child Population Estimates.**—A letter, dated July 4th, from Dr. C. Milliken Smith drew the attention of the Council to G.R.O. Circular No. 3/1953, the effect of which would be that child population statistics would not in future be available to County District Medical Officers of Health. It was agreed that further consideration be given by the General Purposes Committee to this matter at its next meeting, so that the position could be discussed with Mr. Blaikley.

170. **Treatment of Poliomyelitis in Hospitals.**—A letter, dated July 20th, 1953, from Dr. W. S. Parker drew attention to the recent issue by the Ministry of Health of Circular RHB/53/75 and to the fact that the circular had not been issued to Medical Officers of Health. It was agreed that it be pointed out to Dr. Parker that the circular in question had now been issued to Medical Officers of Health.

171. **Ministry of Health Circulars.**—A letter from Dr. W. S. Parker, which referred to circulars issued by the Ministry of Health to Executive Councils, was received.

172. **Diphtheria Immunisation Annual Returns.**—A letter, dated August 5th, from the Ministry of Health contained proposals for a new form of annual return which would facilitate calculation of the proportion of children in any age group who had had a course of immunisation within the preceding five years. It was agreed that the Society raise no objection to the proposals contained in the letter.

173. **Welfare Centres.**—A letter, dated August 17th, from the Women Public Health Officers' Association referred to a resolution carried at the annual general meeting of that organisation deploring the fact that health visitors were often expected to conduct welfare centres in premises the hygiene and cleanliness of which were unsatisfactory. It was agreed that the Association be informed that it was the view of the Society that this was a matter for local consideration only.

174. **Collection and Publication of Tuberculosis Notification Statistics.**—A letter, dated August 11th, from the Ministry of Health contained the suggestion that notifications of T.B. should in future be included on the Medical Officer of Health's weekly return of infectious diseases, in order that they could be published weekly by the Registrar-General in the same way as other notifiable infectious diseases. It was agreed that the Ministry be informed that the Society approved generally the suggestions contained in the letter.

175. **Royal College of Midwives.**—The Society's attention was drawn by the Royal College of Midwives to two resolutions which had been passed at the 71st annual general meeting of the College :—

(*a*) " That the midwife is the person to decide whether home conditions are suitable for home confinement."

It was resolved that the Royal College of Midwives be informed that it was the opinion of the Society that the midwife's opinion regarding the suitability of home conditions for home confinements should always be taken into consideration, but that the decision should be taken by the Medical Officer of Health or the General Practitioner, after considering that opinion, and the opinions of others, including that of the patient herself.

(*b*) " That since the Ministry of Housing has mainly removed building restrictions the Royal College of Midwives should urge all local health authorities to provide or build houses for midwives. The houses should be of special design and independent of the Housing Department."

It was agreed that the Royal College of Midwives be informed that this was a question for local consideration.

176. **Tuberculosis Conference.**—A letter, dated August 25th, from Dr. J. S. M. Gray (C.M.O., Renfrewshire) was received. The letter suggested that the Society should endeavour to arrange for a National Conference to be run jointly by the Society and the British Tuberculosis Association, to be held possibly at Oxford or Cambridge during the summer of 1954, in order to bring about a closer link between the curative and preventive fields of T.B. work. The Council considered carefully the suggestion contained in Dr. Gray's letter but felt that the aims of such a conference would be better obtained by smaller conferences arranged locally.

177. **Smallpox.**—A letter, dated September 2nd, from the Ministry of Health enclosed draft instructions which the Ministry of Pensions and National Insurance proposed to send to their local officers as to the lines on which they should proceed to carry out their statutory duties in an area affected by smallpox. The Ministry sought the Society's views on the scheme set out in the draft circular. It was agreed that the Ministry be informed that the Society agreed with the Ministry's point of view in the matter and that it was felt that Medical Officers of Health should co-operate in the manner suggested.

On the question of the draft circular to be issued, it was agreed that the Ministry of Health be asked to recommend to the Ministry of Pensions and National Insurance that the words " or other appropriate officer of the local authority " be removed from the circular, so that the Medical Officer of Health only be responsible for operating the scheme.

178. **Employment of Persons Suffering from Tuberculosis.**—A letter, dated September 8th, from Dr. J. A. Scott stated that the Conference of Medical Officers of Health of London and the Home Counties had recently considered the question of the employment of tuberculous persons, particularly in view of the Private Act recently obtained by the County Borough of Huddersfield, which enabled that authority to pay compensation to persons suffering from T.B. who gave up their work on the advice of the Medical Officer of Health, and were on that account precluded from earning their living. It was resolved that the letter be referred to the Sub-committee which is dealing with the question of the Rehabilitation of Disabled Persons, and that any comments of that Sub-committee be considered by the General Purposes Committee at its next meeting.

Arising from consideration of this matter it was resolved that the Central Office should collect information from the Medical Officers of Health of local health authorities regarding the details of any Private Act which affected the work of the Medical Officer of Health, so that this information could be made available to any officer for the preparation of recommendations to his own local authority.

179. **Training of District Nurses.**—A letter from the Ministry of Health invited the Society to appoint a representative to serve on the Working Party which was being set up to consider the question of training for district nurses for both England and Scotland. The Terms of Reference of the Working Party are as follows :—

" To consider what training it is desirable that registered nurses and enrolled assistant nurses should undertake prior to their employment on home nursing duties and the means by which such training should be provided."

It was resolved that the Ministry be informed that the Society wish to nominate Dr. T. M. Clayton, M.O.H., Coventry, to serve on the Working Party.

180. **Sanitary Inspectors Working Party.**—The attention of members was drawn to the publication of the Report of the Working Party on the Recruitment, Training and Qualifications of Sanitary Inspectors. The President referred to the fact that Dr. J. S. G. Burnett (M.O.H., Preston C.B.) had been a member of the Working Party (following his nomination by the Society) and it was resolved that the thanks of the Society be conveyed to Dr. Burnett for his work in this connection.

181. **Fluoridation of Water Supplies.**—The attention of members was drawn to a meeting of the Dental Officers Group, which was to be held on Saturday, October 24th, at 2.30 p.m., at which all members of the Society were invited to attend. The meeting would be addressed by Miss Jean Forrest, of the Ministry of Health, on the fluoridation of water supplies.

182. **Condemned Meat.**—The attention of members was drawn to the fact that meat which had been condemned by the Ministry of Food was now being offered for sale by public auction and that there did not appear to be adequate restrictions imposed upon the purchasers. It was resolved that this question be considered at the next meeting of the General Purposes Committee and that in the meanwhile the Standing Sub-committee for Food Matters be asked to look into the matter.

183. **School Health Service and Handicapped Pupils Regulations, 1953.**—The attention of members was drawn to the designation " Principal School Medical Officer " which had appeared in the new S.H.S. Handicapped Pupils Regulations. This designation had not been included in the draft of the Regulations which the Society had been asked to consider and it was resolved that a letter be addressed to the Ministry of Education objecting to the introduction of this designation without prior consultations.

184. **Representation**

(*a*) *R.S.I. and Sanitary Inspectors Examination Joint Board.*—It was resolved that Dr. F. A. Belam be appointed the Society's representative on the Board for the three-year period commencing January 1st, 1954.

(*b*) *General Medical Services Committee.*—In accordance with the agreed constitution of the General Medical Services Committee of the B.M.A., the Society was informed that the B.M.A. Public Health Committee suggested the nomination of Dr. H. D. Chalke as the members of that committee, and that Dr. S. C. Gawne be nominated deputy to him. The Council endorsed this suggestion.

185. **Life Membership.**—It was agreed that the following recommendation for Life Membership of the Society, from the Midland Branch, be confirmed for submission at the next Ordinary Meeting of the Society :—

Dr. W. Taylor, formerly C.M.O.H., Shropshire C.C., joined the Society in 1922.

186. **Any Other Business.**—The Chairman (Dr. J. M. Gibson) called the attention of members to the definition of a Public Health Service Member of the B.M.A.—a definition which had recently been revised at the A.R.M. of the B.M.A. Although the revised definition was similar to the previous definition so far as it was related to retired Medical Officers of Health, he felt justified in calling the attention of the Council to it because as it stands it means that a Medical Officer of Health on retirement on superannuation can no longer be called a Public Health Service Member of the Association even though he continues to be a member both of the Society of Medical Officers of Health and of the B.M.A. It was resolved that the matter be further discussed at the next meeting of the General Purposes Committee.

There being no other business the meeting was declared closed at 12.45 p.m.

APPENDIX

GENERAL PURPOSES COMMITTEE

A meeting of the General Purposes Committee was held at the Angel Hotel, Cardiff, on Friday, July 10th, 1953, at 8 p.m.

Present.—Dr. H. K. Cowan (in the Chair), the President, Dr. Andrew Topping, the Chairman of Council, Dr. J. M. Gibson and Drs. H. D. Chalke, C. K. Cullen, Miriam Florentin, C. E. Herington, Maurice Mitman, A. A. E. Newth, Mr. J. F. A. Smyth, L.D.S., and Dr. J. A. Stirling.

Dr. Kelynack, Assistant Secretary of the B.M.A., was also present.

Apologies for Non-attendance were received from Drs. F. M. Day, James Fenton, T. Ruddock-West and W. S. Walton.

127. **Minutes.**—The minutes of the meeting of the Committee held on April 17th (PUBLIC HEALTH, July, pages 163, 164) were confirmed and signed by the Chairman.

128. **Whitley Medical Functional Council** (*Min.* 76)

(*a*) *Implementation.*—Dr. A. V. Kelynack reported verbally on the position with regard to the implementation of the awards of the Industrial Court.

(*b*) *Appeals.*—A report was also submitted regarding the position of various appeals that had been heard or were pending.

(*c*) *Assistant Medical Officers' Salary Scales.*—The Committee's attention was drawn to the decision of the Industrial Court following the hearing of the two sides in the claim for increased salary scales for Assistant Medical Officers. It was *resolved* that the Chairman, the Assistant Secretary and the staff of the B.M.A. be congratulated on the successful result of the hearing and that the thanks of the Society be conveyed to them.

(*d*) *Committee "C."*—The Chairman gave a verbal report of the discussions at recent meetings of Committee "C." Arising from the consideration of this report, it was proposed to recommend to the Council that it be suggested to the B.M.A. that no further claims for increased salary scales be presented to the employers' side for a period of 12 months. It was proposed as an amendment that this period should be six months instead of 12 months but after further discussion these proposals were withdrawn and it was agreed that no representations should be made for the time being.

(*e*) *Arbitration: Machinery.*—It was reported that, at the A.R.M. of the B.M.A., the meeting had agreed that strong representation should be made to the Ministry of Health for the setting up of a Whitley Court of Arbitration.

(*f*) *Restrictive Practices.*—A letter, dated May 19th, from the County District Group drew the attention of the Committee to the agreement in Committee "C" which resulted in the issue of M.D.C. Circular No. 16 and to the fact that the words "Any Other Business" in the circular might be misconstrued; the letter stated that a case was known where a Council had demanded and received the amount received by the M.O.H. for the publication rights of a book of which he was the author.

It was reported that this matter had been considered by the Staff side of Committee "C" and it was felt that, since the wording in the conditions of service was exactly the same as a clause in the conditions of service of other chief officers and it was not likely that employing authorities generally would interpret the clause unreasonably, there was no need to take immediate action to reopen this matter with the management side. Informal inquiries were, however, being made to see whether difficulties had been experienced by other chief officers.

(*g*) *Part-time M.O.H.s.*—A letter, dated June 12th, from Dr. Nevil H. Linzee sought the advice of the Society on the time which had been allocated for him to carry out his duties as part-time M.O.H. to two separate authorities. It was *resolved* that Dr. Linzee be informed that the Society had agreed that it would not attempt to interfere in any way with the allocation of time which had been given by various authorities for their officers to carry out their duties and that, in view of this policy, it was not possible to give Dr. Linzee any help in the matter of his dispute with his employing authorities.

129. **Review of the Society's Finances** (*Min.* 78).—The Committee had before them the audited accounts of the Society for the session 1951–52, together with the report of the Administrative Officer, on the estimated expenditure for the current session, and a document, prepared by Mr. G. L. C. Elliston, which set out his suggestions for the possible taking over by *The Medical Officer* of the publication of the Society's journal. It was *resolved* that a Sub-committee, consisting of Drs. H. K. Cowan, James Fenton, J. M. Gibson, C. E. Herington and Andrew Topping, be appointed to consider all matters relating to the finances of the Society and the publication of the journal and to submit a report to the General Purposes Committee for the session 1953–54.

130. **"Public Health"** (*Min.* 78).—The Administrative Officer reported that he had discussed with the printers of the journal, Messrs. H. R. Grubb, Ltd., the question of the prompt publication of the journal in accordance with the printing schedule which had already been agreed. The printers had promised to co-operate in every way possible with the Society in its effort to publish the journal at a set date each month. The Committee requested that a report be submitted to them on the result of the renewed efforts in this direction and that, if the printers failed to keep to the agreed schedule, the Society should consider making alternative arrangements for the publication of the journal.

131. **Training of Health Visitors** (*Min.* 79).—It was reported that further meetings of the Sub-committee had been held and that the final draft of a document for presentation to Council was in course of preparation. It was reported that, at the last meeting of the Sub-committee, members were in some doubt as to whether reference should be made in the Society's evidence to the relationship between the health visitor and the almoner both in the hospital and local health authority services. It was the opinion of the majority of the members present that some reference in the draft evidence should be made to co-operation with both types of almoner.

132. **D.P.H. Committee** (*Min.* 81).—It was reported that the D.P.H. Committee had held further meetings and intended to submit a memorandum to the September meeting of Council.

133. **British Medical Journal** (*Min.* 85).—It was reported that the School Health Service Group were still not completely satisfied with the Editorial policy of the *British Medical Journal* so far as the School Health Service was concerned. The Committee considered that the Society had taken every possible step to convey to the Editorial Board the feelings of the Society in this matter and that no good purpose would be served by raising the matter again.

134. **Civil Defence** (*Min.* 87).—It was reported that Dr. W. S. Walton had asked that, owing to his unavoidable absence from the meeting, consideration of his draft of a letter to be sent to the Ministry of Health be deferred until the next meeting of the Committee, which he hoped to be able to attend.

135. **Public Health Service Defence Trust** (*Min.* 89).—It was reported that letters were in course of dispatch to members of the Public Health Service who had not made a contribution to the Trust for the current year and that the results to date were encouraging. Certain members of the Society had volunteered to assist the Trustees in this matter.

136. **Annual Report of M.O.H.** (*Min.* 95).—It was reported that no reply had been received from the M.O.H. whose annual report was the subject of discussion at a previous meeting of the Committee.

137. **Children with Defective Hearing** (*Min.* 97).—It was reported that the Ministry of Health had informed the Society in a letter dated July 4th that the Ministries of Health and Education were in consultation on the ascertainment and early training of deaf children of school age and under.

138. **Occupational Health Service** (*Min.* 100).—It was reported that the Committee which was appointed to prepare a document setting out the Society's policy in this matter had held its first meeting and that letters were to be dispatched to all Medical Officers of Health asking for information as to the work which they were at present carrying out both in their local industries and for their own employing authority.

139. **Notification of Infectious Disease** (*Min.* 101).—It was reported that representatives of the Society had interviewed the Chief Medical Officer of the Ministry of Health and senior members of his department on July 3rd. As a result of the discussions, the Ministry had agreed to consider what could be done to meet the wishes of the Society.

140. **Annual Dinner** (*Min.* 102).—It was reported that arrangements were now being made for the annual dinner to be held on October 22nd next. At the request of the President-Elect an invitation had been addressed to the Minister of Education to be the principal guest at the dinner and to propose the health of the Society. Miss Florence Horsbrugh had kindly accepted the invitation.

141. **Presidency of the Society and Chairmanship of Council** (*Min.* 109).—The Committee considered, at the request of the Council, the advisability of the President of the Society being *ex officio* Chairman of Council. It was agreed that Council be informed that it was the opinion of the General Purposes Committee that these two offices should not be amalgamated.

142. **Adoption of Children** (*Min.* 111).—Members had before them copies of the memorandum of evidence which had been submitted by the Society. It was reported that representatives had attended at the Ministry on July 2nd to submit oral evidence in its support.

143. **Foot Deformity in Children** (*Min.* 119).—A further letter, dated June 11th, was received from Mr. Charles A. Pratt in which he requested the Society to review its decision to take no action on his previous letter. It was *resolved* that Mr. Pratt

be informed that the Committee could not alter its decision.

144. **Cost of the National Health Service** (*Min.* 120).—The minutes of the first meeting of the Committee appointed to prepare draft evidence for submission to the Guillebaud Committee were received.

145. **Rehabilitation of Disabled Persons** (*Min.* 122).—It was reported that a formal invitation had been received from the Committee of Enquiry on the Rehabilitation of Disabled Persons for the Society to submit evidence. It was *resolved* that, after consultation with the President-Elect, a Committee be appointed to consider the preparation of evidence, the membership of which would be drawn from members of the Society who were employed within a reasonable proximity to Manchester so that an opportunity could be given to members who were not employed in the London area to take part in the Society's activities.

146. **Cancer Education.**—It was reported that a letter dated May 8th had been received from the Ministry of Health enclosing a copy of a circular which it was proposed should be issued to all local health authorities on the subject of cancer education and requested the Society's comments. In view of the fact that the Ministry had asked for an early reply, the Chairman of the Committee had instructed the Administrative Officer to inform the Ministry that the Society was in general agreement with the contents of the circular. This action was confirmed.

147. **Marie Curie Memorial Foundation.**—A letter, dated June 17th, from the Marie Curie Memorial Foundation informed the Society that a series of leaflets were being prepared to deal with Cancer Education. It was proposed to include a list of authorities and organisations who were willing to assist cancer patients in various ways. It was agreed that the Foundation be informed that the Society had no comment to make on this proposal.

148. **Notification of Leprosy.**—A letter from the M.O.H. of two Rural District Councils drew the attention of the Society to two cases of advanced leprosy which had come to his notice. The M.O.H. had suggested that the Society might again approach the Ministry of Health to secure that notification of leprosy be dealt with in accordance with the usual procedure for the notification of infectious diseases. It was reported that the opportunity had been taken by the representatives of the Society who had recently discussed with the Ministry of Health the question of the notification of infectious diseases to raise this matter again with the Ministry. The Ministry, however, were not prepared to alter their view.

149. **Investigation of Hospital Outbreaks of Puerperal Infection.**—A letter, dated May 29th, from the Ministry of Health contained details of a suggestion for the Ministry to appoint a special team consisting of a Medical Officer from each of the Sections for Epidemiology and Maternity and Child Welfare with one of the Ministry's public health nursing officers whose duty it would be to visit maternity units where outbreaks of puerperal infection occurred. The proposal had arisen from the fact that there had recently been fairly large outbreaks of infection in hospital maternity units which had come to notice very late. It was *resolved* that the Ministry be informed that it was the considered opinion of the Society that the Medical Officer of Health should continue to be responsible for the investigation of such outbreaks but that, in carrying out his statutory duties, he would no doubt be very glad to avail himself of the services of the special team in cases of difficulty.

Members present were very surprised to learn of the late notifications and were concerned to know whether this was due to the non-compliance by hospital authorities with the statutory requirements or to the neglect of Medical Officers of Health. It was considered to be unlikely that the latter was the case in view of the fact that all Medical Officers of Health were aware of the need for prompt handling of outbreaks of this nature.

150. **Employment of Tuberculous Patients.**—A memorandum prepared by the T.B. Group dealing with the employment of tuberculous patients was referred for consideration by the Committee which would prepare evidence on the question of rehabilitation (reference, *Min.* 145 above).

151. **Standing Sub-committee for Food Matters.**—It was reported that the recommendations of the Food Standards Committee relating

(*a*) to the use of Antioxidants in Food, and

(*b*) to revised limits for the Fluorine Content of Acidic Phosphates and Food Containing Them

had been forwarded to the Society for comment. The Standing Sub-committee for Food Matters had considered the recommendations and were of opinion that no comments should be made by the Society.

152. **World Conference on Medical Education.**—A letter, dated June 15th, from Dr. Grey E. Turner gave information regarding the first World Conference on Medical Education, which was to be held in London from August 24th to 29th next. It was agreed that the President, Dr. Andrew Topping, be appointed the Society's representative at this conference.

153. **Immunisation.**—A letter, dated June 16th, from Dr. E. D. Irvine, Exeter C.B., drew attention to the practice in Salford of permitting trained nurses to give doses of prophylactic to children for immunisation purposes against diphtheria, whooping cough, etc., and sought the Society's advice as to whether this practice was being carried on in other areas. It appeared that the Medical Defence Union and the Medical Protection Society considered that the responsible M.O.H. would be at fault if he permitted nurses to carry out these immunisations in the event of alleged ill effects from the injections and claims arising therefrom. It was concluded that, until this became a recognised and accepted practice, there was a danger that a Medical Officer of Health might be held negligent in delegating to nurses the task of giving such injections.

Members present felt that this was a reasonable practice provided a Medical Officer was on the premises at the time of the injections and that the matter be taken up with the Medical Defence Union. It was also agreed that the County and County Borough Groups of the Society be asked for information as to the practice in the areas of the various local health authorities.

154. **Prevention of Food Poisoning in School Canteens.**—A letter, dated June 17th, from the Ministry of Education enclosed for the comments of the Society a draft circular on the Prevention of Food Poisoning which it was proposed should be sent out to local education authorities. It was *resolved* that Drs. A. A. E. Newth and J. A. Stirling consult together and instruct the Administrative Officer as to the comments which should be forwarded to the Ministry on behalf of the Society.

155. **Sanitary Officers' Regulations.**—The attention of the Society was called to a case of disturbed relationship between the M.O.H. of a Rural District and his authority regarding the relative positions of the M.O.H. and the Chief Sanitary Inspector and the local authority's interpretation of the Sanitary Officer's (Outside London) Regulations.

It appeared that the Ministry of Health were already dealing with this matter and it was agreed that, in the event of the Ministry settling the dispute to the satisfaction of the M.O.H. concerned, no action would be called for by the Society.

156. **General Nursing Council.**—An invitation was received from the Minister of Health for the Society to submit suggestions to him regarding the appointment of members to the General Nursing Council. It was *resolved* that the following suggestions be made :—

(*a*) A Registered Nurse employed in service under Part III of the National Health Service Act—Miss E. Robinson, Superintendent Health Visitor, Lancashire County Council.

(*b*) Three persons having had experience in the control and management of hospitals—Drs. James Grant, M.O.H., Gateshead C.B., J. F. Warin, M.O.H., Oxford C.B., and John Yule, M.O.H., Stockport C.B.

157. **Industrial Disease.**—A letter, dated July 6th, from the Ministry of National Insurance invited the Society to submit evidence to the Departmental Committee which had been set up to review the present provisions of the Industrial Injuries Act. It was agreed that a Sub-committee be appointed, consisting of members of the Society nominated by the President-Elect, to prepare draft evidence.

158. **Research.**—It was reported that the M. & C.W. Group had considered the suggestion of the Research Committee that there should be an enquiry into the work of the M. & C.W. clinics, and the M. & C.W. Group should be responsible for the carrying out of the investigations. The Group had agreed that such research would be most advisable and had decided to form a study group which would outline a programme for a comprehensive research. The Group asked whether the Society would be willing to accept the responsibility for the payment of the travelling and subsistence expenses of the members of the study group in dealing with this matter on the Society's behalf.

It was agreed that the M. & C.W. Group be informed that the Society would be prepared to cover such expenditure up to a maximum of £30 and that authority be given for the utilisation of the services of the administrative staff in the secretarial work involved. It was also agreed that an approach be made to the Medical Research Council to see whether the Society could obtain some financial help towards the cost of carrying out this research project.

159. **Programme for the Session 1953-54.**—It was agreed that the following be the recommended programme of meetings for the Session 1953–54 :—

1953

Thurs., Oct. 22nd, 7.30 p.m.—Annual Dinner, Piccadilly Hotel,
Fri., Oct. 23rd, 10 a.m. —Council.

Thurs., Dec. 10th, 5.30 p.m.—Annual General Meeting.
Fri., Dec. 11th, 10 a.m. —General Purposes Committee.
1954
Fri., Feb. 19th, 10 a.m. —Council.
Fri., April 9th, 10 a.m. —General Purposes Committee.
Fri., June 18th —Provincial Meeting of Council and Ordinary Meeting of the Society, Manchester.
Fri., July 16th, 10 a.m. —General Purposes Committee.
Thurs., Sept. 16th, 5.30 p.m.—Ordinary Meeting—Installation of the President.
Fri., Sept. 17th, 10 a.m. —Council.

160. **Representation.**—The following were appointed to represent the Society :—

(*a*) *North Regional Association for the Deaf.*—Executive Committee—Dr. W. S. Walton.

(*b*) *National Housing and Town Planning Conference.*—Eastbourne, Oct. 28th to 30th—Dr. J. A. Stirling.

The meeting terminated at 10.45 p.m.

HOME COUNTIES BRANCH

President : Dr. J. Maddison (M.O.H., Twickenham M.B., and Area M.O., Middlesex).

Hon. Secretary : Dr. F. G. Brown (M.O.H., Wanstead & Woodford M.B., and Area M.O., Essex).

Pest Control

There was a good attendance for the visit of the Branch to the Pest Infestation Laboratory (Department of Scientific and Industrial Research) at Slough, Bucks, on September 11th, 1953.

In the unavoidable absence on holiday of the Director, G. V. B. Herford, Esq., members were welcomed by Dr. E. A. Parkin, who gave a brief outline of the history of the Laboratory, which was started in 1940 as a result of co-operation between the Department of Scientific and Industrial Research and those sections of industry concerned with the handling of grain and grain products. While it was primarily formed to deal with peace-time conditions of infestation, the whole of its activity was at first directed to the solution of the problems which arose or were intensified as a result of the war. Chief among these problems was the conservation of the security stocks of food, especially grain and flour, which formed such a vital part of the nation's economy.

The Laboratory was still primarily concerned with the insect and mite pests of stored foodstuffs, especially cereals, and of other stored products such as tobacco, hides, wool, etc., but work was also undertaken on certain physical, chemical and mycological aspects of food storage. On the staff of the Laboratory were entomologists, chemists, plant physiologists and a mycologist, working together as a team.

Dr. Parkin said it was not possible in the course of one afternoon to see the whole of the work of the Laboratory, and he had therefore selected the following sections for the conducted tour of the premises : Insecticides, Biochemistry, Fumigation, Biology. The members' interest was held throughout the afternoon and the time went all too quickly.

NORTH-WESTERN M. & C.W. & S.H.S. SUB-GROUPS

President (*1952-3*) : Dr. Margaret Sproul (Sen. M.O., M. C.W., Salford C.B.).

Hon. Secretary : Dr. E. M. Jenkins (Sen. S.M.O., Manchester C.B.).

A meeting of the Groups was held in the Public Health Committee Room, Third Floor, Town Hall Extension, Manchester, on Friday, April 24th, at 5 p.m. Twelve members were present.

Plastic Surgery

The speaker, Mr. Frank Robinson, senior assistant surgeon to Mr. A. H. R. Champion, the plastic surgeon, was introduced by the President. Mr. Robinson opened by apologising for his presence and explained that he was giving the talk on Mr. Champion's behalf.

There followed a most interesting talk on plastic surgery generally, profusely illustrated by lantern slides. Mr. Robinson explained that plastic surgery was reconstructive in nature as opposed to the more usual type of destructive surgery. The main scheme was to transplant tissue to replace original tissue destroyed. The Plastic Unit in the North-West had 72 beds at Wythenshawe Hospital for adults and children which dealt with burns injuries, contractures following burns, other scarring and facial fractures. For the latter purpose there was in addition to the surgical team a dental team, the latter being necessary for dental face fractures and tumours of the mouth and lips, congenital deformities such as harelip, cleft-palate and syndactyly.

At Christie's Hospital a team was concerned with the excisions of neoplasms of the face and the replacement of tissue by skin grafts or skin flap grafts, also similarly for the treatment of melanomata. At the Babies Hospital, Burnage, the work consisted mainly of cleft-palate and harelip operations and burns in the two year olds. Among the slides shown and explained were the following :—

1. *Bilateral syndactyly.*—Operation recommended at two years of age, done under local anaesthetic followed by splinting.

2. *Hairy naevi or melanomata* excised before puberty and the skin grafts taken from the side of the chest.

3. *Bat ears* required operation at about five years of age which consists of removal of some cartilage.

4. *Bilateral harelip.*—Occurred in about one in 1,000 births. Harelip might be slight or complete, and the first operation should be done at two to three months in babies weighing not less than 10 lb. and gaining. The second stage of the operation was required for the other half of the lip and front of palate. The second operation was often required at school age and the third at about 18 years of age. If the palate was closed at 18 months, speech therapy would be required but was usually impracticable before about five years. It was important to close the posterior end of the cleft palate since the dental plate could occlude deficiencies further forward. Dental splints were required in nearly all harelip cases and must be worn for about six months. Grafts in the mouth usually took well.

5. *A case of severe facial injuries* in a drunk epileptic person. Operation took nearly two hours and *x*-ray was subsequently needed for keloid formation.

6. *Avulsion of the scalp* as a result of hair catching in revolving machinery. Skin of upper nose and eyelids removed as well as whole scalp. Loss of body fluid extensive and three to four pints of serum required to keep the haemoglobin up to 80%. Many grafts required. (Patient awarded £7,500.)

7. *Crushed fingers*—required flaps from abdominal wall. A second operation with separate grafts required to produce individual fingers, the original pedicle being detached after only three weeks.

8. *Bone graft* for saddle defect of nose.

9. *Burn* of chest and abdomen.

10. *Hands* of child after grasping bar of electric fire. Burns were a frequent type of cases. If there was a surface loss of 5% in babies and 10% in children and adults the condition was serious and transfusions of plasma were needed to offset fluid loss. Shock must first be treated and only first-aid dressings applied to start with. Anaemia was frequent and persistent and blood is required at weekly intervals. Local dressings of saline or vaseline gauze, or even exposure to air with some sulphanilamide dusting powder, was all that was required. Parental grafts took, but disappeared spontaneously in about three weeks after healing, leaving a raw area again.

11. *Large body scar* with limitation of arm movements. Scar replaced with grafts resulting in a 50% improvement.

12. *Enormous osteoclastoma of the jaw.*—Excised with resultant great bleeding. Face reconstructed later with section of ilium including iliac crest which was used to form the angle of the mandible.

An interesting discussion followed, after which Dr. Wilkinson proposed a vote of thanks saying how much we had learned from the talk, which was most interesting and illuminating. The vote of thanks was very warmly applauded.

A meeting of the Sub-Groups was held at the Liverpool Children's Rest School of Recovery, Greenbank Lane, Liverpool 17, on Friday, May 15th, 1953, at 5 p.m. Twenty-two members were present.

Cerebral Palsy

The first speaker, **Dr. R. J. Derham,** visiting paediatrician and deputy medical superintendent, Alder Hey Children's Hospital, was then introduced by the President. He opened his remarks by discussing the terminology of the classification of children examined by the spastic unit at the Children's Rest School of Recovery. He pointed out that " spastics " was an unsuitable name and that the children in the group concerned should be called cases of cerebral palsy, the name used by Dr. Phelps, of Baltimore. This name covered a group of varied conditions of which only 40% were spastic, 40% were athetoids, and the remainder ataxics due to cerebellar dysfunction. Differential diagnosis was often difficult. Important factors to take into consideration were the intelligence quotient and the emotional element. It was especially difficult in the severely handicapped, the speechless and deaf children. It was estimated that in the whole group about half had an intelligence quotient of 70 or over, and about a quarter of 50 or less.

The aetiology was in doubt in many instances but could be ascertained in about one-third or, at the most, half the cases. The causes might be pre-natal, during delivery, or post-natal,

and the following were the commonest—the Rhesus factor in about a third of the cases, prematurity or immaturity about a third. The remaining third were due to toxaemia and eclampsia, toxo-plasmosis, mechanical difficulties and delay causing asphyxia or haemorrhage of the brain. Amongst the causes of the latter condition were convulsions, encephalitis, cerebral asphyxia and possibly thrombosis. The site of the lesion determined the type of defect. Quadroplegia was due to widespread damage and was often accompanied by sensory defects. Asphyxia was thought to be the main cause of athetosis, probably resulting from damage to the basal nucleii.

Treatment was a matter of team work. Emotional disturbance and education must be dealt with. Medically, the treatment was mainly pharmacological, *e.g.*, drugs were needed to relieve tension. Amongst those tried were phenobarbitone, which produced mental clouding during prolonged use, prostigmine, used in certain cases of hemiplegia and reported as giving good results in 50% of cases. Curare (elixir of B.D.H. or myomecin) was used for athetosis with tension and spastics with painful spasms, but its action was only temporary. The belladonna type of drugs was also tried, but all required to be used over long periods to determine the effect.

Early recognition of the condition was essential and treatment should be started at a very young age. As a result of the setting up of the unit at Liverpool, cases were coming from hospitals, M. & C.W. and welfare services. An O.P. department was needed in conjunction with cerebral palsy units or schools.

Mr. F. C. Dwyer, consulting orthopaedic surgeon, next spoke. He stressed the need for team work and the difficulty of diagnosis. Cases originally thought to be due to lesions of the pyramidal tract sometimes turned out to be a spastic type. Intelligence quotients, though difficult to assess, were invaluable and often a guide to diagnosis. The monoplegics with less cerebral involvement were the most likely to benefit from treatment. Children with extensive athetoid movements even with a high I.Q. were often difficult to treat because of the severe involuntary movements. Contractures were common in spastics, but did not develop in athetoid types.

Physiotherapy was the most important form of treatment and the surgeon's job was mainly to help with the selection of appliances. Of these, the hinged type of knee brace with probably a corset top inside or outside irons, for eversion or inversion deformities helps to improve the gait and confidence of the child. Very few operations are necessary and no bony operations indicated. Fractures in athetoids are very serious. The most valuable operations were the shortening or elongation of the tendo achillis, especially the former. Occasional tenotomy of adductor muscles and occasional shortening of the wrist joint which allowed elongation of spastic muscles were valuable.

Dr. A. M. Brown, senior assistant school medical officer, explained that he was particularly concerned with the administrative aspects of providing treatment and education. In this particular school 20 cerebral palsy children were thrown together with 25 other physically defective, though less handicapped, children. Out of a population of approximately 130,000 children in Liverpool between the ages of five and 16 there were to their knowledge 160 cases of cerebral palsy. They were satisfied that there were very few cases not included in this figure, which represented an incidence of 1·2 per 1,000 school children (cf., Dr. Derham's figures).

In estimating what provision is necessary in any area for the schooling of County primary children it might be useful to record how their 160 cases are placed :—

(1) 50, *i.e.*, 30%, had been classified as ineducable and had been notified under Section 57(3).

(2) Of the 110 educable children :
- 46, *i.e.*, 30%, were in Ordinary Schools ;
- 32, *i.e.*, 20%, were in Special Schools for physically handicapped pupils ;
- 17, *i.e.*, 10%, were in Special Schools for educationally sub-normal pupils ;
- 15, *i.e.*, 10%, were in the Spastic Unit.

At the preliminary ascertainment they had found that :—

(1) Of the hemiplegics ... ... 22% are ineducable.
„ paraplegics ... ... 36% „ „
„ spastic quadriplegics 67% „ „
„ athetoid quadriplegics 19% „ „

(2) Of the educable children it was interesting to note that the median I.Qs. were distributed as follows :—

Hemiplegics	82
Paraplegics	80
Spastic quadriplegics	80
Athetoid quadriplegics	73

Of the afflicted children below five years only 17 were known out of an estimated number of 80. Children were referred to the unit by hospitals, welfare services and sometimes by parents. They were seen first by Dr. Brown and the psychologist who

sorted them into the categories referred to above. At the same time, wherever they were subsequently sent to, parents were advised by the physiotherapist about the care and treatment.

Those not sifted out or found to be ineducable were referred for examination by the team of the spastic unit and subsequently recommended for ordinary or special schools or for the spastic unit. It was found that good results could be expected in cases with an I.Q. as low as 65.

All the palsied children in the unit and outside were seen again from time to time by the panel and it was found that the severer cases were best placed in a residential rather than a day school, because at the latter the daily transport was thought likely to be detrimental.

Next, a film was shown recording the progress of a cerebral palsy child of the athetoid type under treatment. A lively discussion then followed which clearly showed the great interest taken in all that had been said and seen. Many members asked questions, particularly of Mrs. Floyer, the educational psychologist who did the initial assessments, and Miss Long, headmistress of the Greenbank School, also answered many questions. At the end of the discussion a vote of thanks was very ably proposed by Dr. Bennett to all the members of the team including the educational psychologist and head teacher. She also expressed the grateful thanks of the members to Dr. Robertson for organising such a comprehensive and interesting visit and to Miss Long for the most excellent tea which was provided upon arrival.

There followed, in a large gymnasium-type hall, a demonstration of the apparatus used and of patients under treatment. Miss Ursula Brown, senior physiotherapist to the Unit, answered questions and demonstrated certain forms of treatment. The meeting broke up slowly, many members being very reluctant to leave.

The Annual General Meeting was held on June 26th in the Council Chamber, the Castle, Chester. A short committee meeting was held betorehand. Seventeen members were present at the main meeting.

Officers for Session 1953-54. Dr. Hilary Crewe was proposed as President for the coming session by Dr. Caroline Crystal and seconded by Dr. Mary Melville. This was the only nomination and was carried unanimously.

Dr. Margaret Sproul, the retiring President, was unanimously elected Vice-President.

Dr. E. M. Jenkins, the Honorary Secretary, was re-elected to that post.

The following were re-elected to the Committee:—Drs. Butters, Bennett, Crystal, Craig, Knight, Walker, Wilkinson and Sproul (Vice-President).

The representatives on the Maternity and Child Welfare Group and School Health Service Group were re-elected, *i.e.*, Drs. Butters and Sproul to the former, and Drs. Wilkinson and Jenkins to the latter.

A letter from the Administrative Officer of the Society was read in which he agreed that in future he would notify the Honorary Secretary of all new members or members newly arrived in the region who wish to join the Sub-Groups.

A tour of the City walls followed under a very able guide, and much valuable information was given and many points of great historical interest were drawn to the attention of the members. Just before 5 p.m. a return was made to the Castle where a very excellent tea was provided.

A vote of thanks to the Cheshire County Council and to the guide was proposed by the Honorary Secretary and warmly applauded.

COUNTY DISTRICT GROUP

President: Dr. J. D. Kershaw (M.O.H., Colchester, M.B., M.O., Essex).

Hon. Secretary: Dr. E. H. Pringle (M.O.H., Worthing, M.B.).

A General Meeting of the Group was held at the London School of Hygiene, Gower Street, London, W.C.I, on Saturday, September 19th, at 11.30 a.m. The President was in the chair and there were approximately 70 members present.

The minutes of the previous General Meeting held on September 27th, 1952, were approved and signed.

Local Government Reorganisation

A discussion took place on Local Government Reorganisation with particular reference to the recent Report and Recommendations of Representatives of the County Councils' Association, the Urban District Councils' Association, the Rural District Councils' Association and the National Association of Parish Councils'.

Dr. R. A. Hoey opened the discussion and spoke on a memorandum he had written on the subject, which had been circulated prior to the meeting. Many speakers took part in the discussion that followed, and it was finally resolved:—

(*a*) That the Executive Committee should undertake an up-to-date Survey of the amount of decentralisation of Part III Services, and that the Administrative Officer be asked to work out the details.

(*b*) That the County District Group instructs its representatives on the Council of the Society to press for the co-option of one of its members to membership of the Sub-Committee which is considering the preparation of draft evidence for submission of the Guillebaud Committee.

(*c*) That the Executive Committee be requested to consider the preparation of a document for presentation to the above Sub-Committee and to brief the Group representattive on the recommendations he makes to the Sub-Committee.

DENTAL OFFICERS' GROUP

President: Mr. S. B. Newton, L.D.S.

Hon. Secretary: Mr. J. F. A. Smyth, L.D.S. (Prin. S.D.O., Gloucester).

Group Council Meeting 18th

A meeting of the Council of the Dental Officers' Group was held on Saturday, July 18th, 1953, at 10 a.m. The Chairman of the Council, Mr. J. V. Bingay, M.B.E., presided and also present were Messrs. K. Batten, M. Cohn, R. B. Dinsdale, J. Fletcher, S. B. Newton, P. G. Oliver, J. C. Robertson, J. F. A. Smyth, A. G. Taylor, K. C. B. Webster and J. Young. Mr. B. D. Britten, Observer from the Public Dental Officers' Group of the British Dental Association also attended. Apologies for absence were received from Miss Hunt and Messrs. Fleming and Kew.

The minutes of the previous meeting having been confirmed and signed the following matters arising were commented on:—(1) *Constitution of the Group.* Mr. Webster reported that the Rules Sub-Committee had met and had made considerable progress. It was hoped that the Sub-Comittee would complete its task before the end of the year. (2) *Research Committee of the Society.* Mr. Smyth reported that Mr. Fletcher had now been formally co-opted to this Committee. A letter had also been received from the Royal Sanitary Institute asking for the nomination of a dental member of the Society to the Institute's

Committee on Fluorides. The Executive of the Group had put forward Mr. Fletcher's name. The action of the Executive was confirmed. Mr. Fletcher reported that he had heard from the Secretary of the Royal Sanitary Institute and its Fluorides Committee had been awaiting the Report of the U.K. Mission to North America to study the subject. He expected that now that the Report had been published the Commitee would shortly again meet. (3) *President of the Society.* The Hon. Secretary reported that Dr. Metcalfe Brown had been elected President of the Society. It was pointed out that according to the Rules of the Society the President was an *ex-officio* member of all Groups. It was resolved that an invitation to attend Group Meetings should be sent to him. (4) *Preventive Dentistry.* Mr. Bingay reported that he and Mr. Webster hoped shortly to present their report on this subject to the Joint Committee. In this connection it was noted that the U.K. Mission to North America to study Fluoridation as a means of controlling Dental Caries had issued its Report. It was resolved that Miss J. R. Forrest of the Ministry of Health, who was a member of the Mission, should be asked to speak on the subject at the next Group Meeting and that it might well be made the subject of a Joint Meeting with the School Health Service Group. (5) *Local Government Superannuation Act.* Mr. Oliver briefly reported on certain matters contained in the Bill. Mr. Webster thought it would be valuable if the Hon Secretary and the Hon. Editor of *Transactions* were to approach the Secretariat of the Society with a view to those points in the New Act which affected Public Health officers being discussed in the Society's Journal.

Correspondence

(1) *Notices of Meetings.* The Administrative Officer had informed the Group that in future it was proposed to include notices of all Group and Branch Meetings in a monthly circular to all members of the Society and in PUBLIC HEALTH. The Group Council feared that this practice, instead of the issuing of individual notices of Group meetings to Group members, might adversely affect attendances at meetings. The Hon. Secretary was instructed to point this out together with a reminder that as the Group already paid the Society for this service no saving of the Society's fund would result.

(2) *Guillebaud Committee.* The Society had been asked to give evidence before this Committee and had set up a Sub- Committee for this purpose. Dental representation had been secured on this Committee and the Executive had nominated Mr. Bingay to represent the Group. The action of the executive in so doing was confirmed. In reporting Mr. Bingay said that he had been asked to provide figures showing the comparative costs of Dental treatment in the general dental service and the local authority dental services. So far his researches had shown that treatment costs per annum were considerably less than those of similar treatment under the general dental service scale of fees. He would like to extend his researches farther afield and would welcome figures from differing types of local authority.

(3) *Dental Whitley Council. Staff Side.* The Hon. Secretary of the British Dental Association's Public Dental Officers Group had asked for the names of the Group's nominees for four members and four deputy members of the Staff Side. In order to maintain continuity while negotiations were in progress the executive had nominated the same eight people as previously, namely: Messrs. Bingay, Donaldson, Fletcher and Webster and as deputies: Miss Stewart and Messrs. Batten, Oliver and Young. The action of the executive was confirmed.

(4) *School Health Service Regulations.* The Joint Committee had considered the 4th draft of the Regulations and the 3rd draft of the circular. The Committee felt that Ministry had gone a considerable way towards meeting their views. There were still, however, a few drafting points which the two Groups wished to see amended. The Hon. Secretary was instructed to inform the Administrative Officer of these points.

Report of Hon. Treasurer. Mr. A. G. Taylor stated that with the exception of certain non-recurring items of expenditure which he had had to meet, the Group had every hope of being able "to live within its income." The Hon. Treasurer was congratulated on the very able way in which he had handled the Group's finances during a very difficult period.

Report of Hon. Secretary. Mr. J. F. A. Smyth said that he would be giving a fuller report on the year's work at the afternoon's Annual General Meeting. He suggested that owing to the reduced number of full Council meetings formal meetings of the Executive should be held at more frequent intervals in order to reduce the amount of business at Council meetings. The Hon. Treasurer and Hon. Secretary were asked to prepare a report on the subject for the next Council meeting.

The Hon. Membership Secretary said that Group membership now stood at 136, of whom 33 were Fellows of the Society, the remainder being Associate Members.

Report of Group Representative on the Council of the Society. Mr. J. F. A. Smyth reported on two meetings of the General Purposes Committee and one meeting of the Council. (These meetings have already been fully reported in previous issues of PUBLIC HEALTH.

Report of Representative on the General Dental Services Committee. Mr. J. V. Bingay said that he had attended all the meetings of the full Committee and many of the meetings of the Sub-Committees. The will-o-the-wisp of child dental treatment was still being chased. Much of the committee's deliberations revolved round the question of remuneration.

Elections. Mr. J. V. Bingay was re-elected Chairman of the Group Council. Mr. J. F. A. Smyth was re-elected Group Representative on the Council of the Society. Messrs Bingay, Fletcher, Smyth and Webster were elected to the Joint Salaries and General Purposes Committee. Mr. J. F. A. Smyth was elected Observer on the P.D.O. Group Committee of the British Dental Association.

PROVISIONAL VITAL STATISTICS

The Registrar-General has announced provisional figures* for England and Wales for the third quarter of this year which show that the birth rate was higher and the stillbirth and infant mortality rates lower than the rates for the corresponding quarter of 1952.

Live Births.—Live births registered numbered 172,976, representing a rate of 15·6 per 1,000 population ; in the third quarters of 1952 and 1951 the corresponding figures were 168,030 and 168,033 respectively, the rate being 15·2 in respect of each quarter.

Stillbirths.—There were 3,709 stillbirths registered, representing a rate of 21·0 per 1,000 total live and stillbirths, compared with 3,714 and a rate of 21·6 in the corresponding quarter of 1952. The figures for the third quarter of 1938 were 6,072 and 37·0 respectively.

Deaths.—Deaths registered numbered 98,588, representing a rate of 8·9 per 1,000 population, compared with 98,613 and a rate of 8·9 in the third quarter of 1952 and 99,961 and a rate of 9·1 in the third quarter of 1951.

Deaths of children under one year of age numbered 3,832 or 22·2 per 1,000 related live births. This rate was lower than that for the September quarter, 1952, when 3,863 deaths represented a rate of 22·8. In the third quarter of 1938 the corresponding figures were 6,629 and 42·5 respectively.

* The Registrar-General's Weekly Return No. 40, 1953. H.M.S.O., price 1s. net (or by post from P.O. Box 569, London, S.E., price 1s. 1½d.).

OFFICIAL NOTICES

United Nations, New York

AFS 60/1/01(2). MEDICAL OFFICERS

United Nations requires administrative Public Health Physician—preferably female—as Assistant to Medical Director in New York Headquarters. Public Health administrative experience essential. Salary $7,780, tax free, plus allowances. Reply United Nations, Bureau of Personnel, New York, N.Y.

JEAN C. TAUPIN,
United Nations, Bureau of Personnel.

County Borough of Preston.

APPOINTMENT OF MALE ASSISTANT MEDICAL OFFICER OF HEALTH

Applications are invited from registered medical practitioners for the above appointment. The duties will include maternity and child health, school health, and port health duties, together with such other duties as may be allotted by the Medical Officer of Health. The possession of the D.P.H. or D.C.H. will be an advantage.

Salary in accordance with the Industrial Court Awards. The person appointed will be required to pass a medical examination and to contribute to the superannuation fund.

Application forms may be obtained from the Medical Officer of Health, Municipal Building, Preston, and should be returned to the undersigned as early as possible.

W. E. LOCKLEY,
Town Clerk.

Municipal Building,
Preston.

Cumberland County Council

APPOINTMENT OF DEPUTY COUNTY MEDICAL OFFICER

Applications are invited for the above appointment. Possession of the D.P.H. or corresponding qualification is essential. Experience in public health administration, civil defence, or the holding of approval by the Ministry of Education for the examination of educationally subnormal children will be a recommendation.

Salary within the range £1,300 (by two annual increments of £100 and one of £50) to a maximum of £1,550 according to qualifications and experience.

The successful applicant will be required to pass a medical examination and to contribute to the appropriate superannuation scheme.

Further particulars may be obtained from the County Medical Officer, 11, Portland Square, Carlisle, to whom applications, together with the names and addresses of three referees, must be sent by Saturday, November 28th, 1953.

G. N. C. SWIFT,
Clerk of the County Council.

The Courts,
Carlisle.

Metropolitan Water Board

APPOINTMENT OF DIRECTOR OF WATER EXAMINATION

The Metropolitan Water Board invite applications from duly qualified medical men possessing wide experience in the chemical and bacteriological examination of water for the position of Director of Water Examination which will shortly become vacant on the retirement of the present holder. The salary scale will be £2,750 per annum, rising, subject to satisfactory service, by annual increments of £150, to £3,500 per annum.

The Director will be required to give his whole time to the service of the Board; to superintend and be responsible to the Board for all examinations, analyses and experiments, and the reports thereon, concerned with the quality of the supply; and to undertake such research work and chemical analyses and investigations, whether of water or otherwise, as may from time to time be required of him. Laboratory and office accommodation, equipment and staff are provided.

The appointment will be held during the pleasure of the Board, and the person appointed will be subject to the Standing Orders, regulations and conditions of service which may from time to time be in force and appropriate. The selected candidate will be required to pass a medical examination by the Chief Medical Officer and to undertake in writing to join the Board's Superannuation and Provident Fund. Pensionable service under the Local Government Superannuation Act, 1937, the Local Government Superannuation (Scotland) Act, 1937, or under the Local Government and other Officers (Superannuation) Act, 1922, may under certain conditions be counted as pensionable service with the Board.

Applications, which must be submitted on the form provided for the purpose, a copy of which can be obtained from the undersigned on receipt of a stamped foolscap envelope, should be addressed to the Clerk of the Board endorsed " Appointment of Director of Water Examination " and must reach the offices of the Board not later than November 16th, 1953. The form contains further particulars concerning the appointment.

Canvassing in any form, direct or indirect, will be held to be a disqualification.

W. S. CHEVALIER,
Clerk of the Board.

Offices of the Board,
New River Head,
Rosebery Avenue,
London, E.C.1.
October 16th, 1953.

Printed by H. R. Grubb, Ltd., Croydon, and Published by The Society of Medical Officers of Health, Tavistock House South, Tavistock Square, W.C.1.